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INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

january • february 1971

some White House Conference proposals
planned variation in Head Start
concepts for working with youth
training for cross-cultural teaching
working for Indians' rights



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his girl is one of the children
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NOEL EPSTEIN



● The White House Conference on Children, the seventh of this century, technically ended on December 18 in Washington, D.C., as the 4,000 delegates from across the country are now back home again. But, as demonstrated in the past, a White House Conference is not really over with the conclusion of the final meeting, the emptying of the hotels, and the boarding of the planes, trains, and buses. In fact, the delegates' departure for home is in a sense only the beginning.

Ultimately, what counts is what happens between now and the next Conference, in 1980, and that depends in good measure on what the 4,000 delegates do back in their communities and how the rest of the Nation responds to their efforts.

The delegates' report to the President is scheduled to be issued in the near future. What it proposes was not available at the time this article went to press. But the Conference did issue preliminary reports, developed by 24 pre-Conference forums of various kinds of experts and laymen from all facets of society, and these reports make clear that a great deal must be done if America is to meet the needs of its children in the seventies.

Indeed, the forum reports tend to condemn us as individuals and as a society for vast neglect of our children's needs. And one—prepared by a group led by Urie Bronfenbrenner, chairman, Department of Psychology and Human Development, Cornell University—warns that, unless we change, "We face the

PRIORITIES FOR CHANGE

some preliminary proposals from
the White House Conference on Children

prospect of a society which resents its own children and fears its youth. Surely this is the road to national destruction."

The reports recommend sharp changes in the attitudes and actions of parents, the schools, the communications media, business, the health system, and all levels of government. While some of the proposals could cost money—and in these cases the reports emphasize that we cannot continue to cut corners with the lives of our children—many others would not. Most, however, would cost us some of our current ways of thinking.

Experimental schools

One proposal, for example, calls for a network of experimental elementary schools free of all current regulations, where many hindrances to education could be overcome and the best known education methods applied. Recommended by a group headed by Dwight Allen, dean of the University of Massachusetts School of Education, the plan reflects the deep dissatisfaction with our school system that runs throughout the reports.

"Participation in these experimental approaches would be at the option of parents and students—no one would be required to attend the experimental schools and no program would be initiated without local support," the report states. "Although no additional money would be required, some legislation

might be necessary to free the schools from present requirements." The experimental schools, in other words, would come from the existing system, and would include perhaps 10 percent of the children now in school.

These experimental schools would be designed to dispel many existing myths about education. These myths, according to the Allen group, include the belief that "children have to go to school to learn," that "schools prepare children for the future," that "schools teach the truth," that "competition in class is good and that grading is good," that "schools can only be changed slowly," that "you shouldn't experiment with children in school," and that "you can't change education without money."

The report of this forum finds that "the risks of maintaining the status quo are now as great, or greater, than the risks of exploring alternatives." It maintains that "our educational mythology severely inhibits ability to respond to the new demands (of our age)."

Similar sentiments can be found in other forum reports. One, concerned primarily with the child and the law, also proposes a system of model elementary schools, a proposal that conceivably could be incorporated into the Allen group's plan. This forum would like to see schools established that are based on democratic principles. Headed by Roy Lee Steinheimer, dean of the School of Law, Washington and Lee University, the group recommends schools where



As part of preparations for the White House Conference on Children, groups of children, like this one, were invited to present their ideas in "moppet briefings" held with the staff.

students are involved "totally in decisionmaking" and thereby experience the democratic process.

"For many, the promise of the American system in terms of justice is largely unfulfilled," the report states, "and faith in the ability of that system to guarantee individual freedom and justice has severely eroded. Now, as probably never before in our history, there is a clear need to understand and appreciate that American democracy is workable and can be fruitful."

The school approach this forum proposes would strive to "make clear that 'democratic process' seeks or encourages a healthy balance between compliance and individual freedom. The democratic process does not eliminate rules or authority, but derives them by nonauthoritarian means; it does not bring an end to the enforcement of order but gives that enforcement a clear rationale."

In another report on the future of learning, a forum led by John I. Goodlad, dean of the Graduate School of Education, University of California at Los Angeles, declares:

"The top agenda item in seeking to enhance learning in the seventies is unshackling the schools. The process must begin by decentralizing authority and responsibility for instructional decisionmaking to individual schools."

This forum recommends a "massive infusion" of government funds for development of experimental schools that would "explore alternatives, test innovations, and create learning options outside the present educational systems." At the root of the problem it finds an implicit denial of diversity. "The schools have been great sorting machines, labeling and certifying those who presumably will be winners and losers as adults. The winners are disproportionately white and affluent. The losers, too often, are poor and brown or black or red."

Still another forum recommends a Presidential commission to study the possibility of free public education starting at age 3 or 4. This group, led by P. Kenneth Komoski, director of Educational Products Information Exchange, Inc., states that more flexible institutions should be created for young children and that considerable attention should be given to the training of both teachers and parents in educating the very young. (The education of parents is another significant theme running through the reports.)

And a forum on "The Right to Read," noting that one out of every four American children suffers from severe reading difficulty, calls for improved research to identify the components of literacy. Seeking the goal of literacy for every child in the Nation, the forum—headed by Edward Summers, professor at the School of Education, University of British Columbia—recommends that the National Reading Council propose legislation that would initiate a coordinated literacy effort.

There can be no doubt that substantial change in our educational system will be urged in the final report of the White House Conference. The same can be said for many other areas of our life.

Reordering priorities

The forum chaired by Dr. Bronfenbrenner, for example, calls for a basic reordering of the priorities of our Nation. "Our society expects its citizens first of all to meet the demands of their jobs and then to fulfill civic and social obligations. Responsibilities to children are to be met, of course, but this is something one is expected to do in his spare time. For when, where, and how?"

The report adds: "The frustrations are great for the family of poverty where the capacity for human response is crippled by hunger, cold, filth, sickness, and despair. No parent who spends his day in search of menial work, and his nights in keeping

ts away from the crib, can be expected to find the me—let alone the heart—to engage in constructive activities with his children or serve as a stable source of love and discipline.

“For families who can get along, the rats are gone, but the rat race remains. The demands of a job, or often two jobs, which often claim mealtimes, evenings, and weekends as well as days; the trips and moves one must make to get ahead or simply hold one’s own; the ever increasing time spent in commuting, the parties, evenings out, and the social and community obligations . . . produce a situation in which a child often spends more time with a passive babysitter than a participating parent.”

The report proposes the creation of a Commission for Children and Families that would strive to stop making the child come last. The commission would be instituted by business and government at both the national and local level and contain representatives from management, labor, and government, as well as parents and children themselves. It would, among other things, undertake the difficult task of trying to change American work patterns. This would include pressing for:

- Flexible work schedules allowing mothers or fathers to be with children when they are most needed—for example, when children get home from school, or when they are sick.

- Minimizing out-of-town, weekend, and evening work. “The introduction of a family oriented personnel policy minimizing such obligations,” the report maintains, “would . . . help attract and hold more able personnel, for the most capable and responsible staff are also likely to be those who care most about their families.”

- Reducing geographic moves. “The impact (of moves from one town to another) is hardest on children,” the report notes, “since healthy psychological development requires some degree of stability and continuity in the social environment from childhood through adolescence. A pattern of life which repeatedly tears the child away from familiar friends, schools, and neighborhoods increases the likelihood of the child’s alienation both within and outside the family.”

- Increasing the number and status of part-time positions “so that employees who wish to give a larger part of their time and energy to parenthood or other activities with children can do so without sacrificing their career opportunities and rate of in-

come.” In this regard, the forum also proposes the drafting and adoption of a Fair Part-Time Employment Practices Act.

“Children need people in order to become human,” the group states. “The fact is fundamental because it is firmly grounded in both scientific research and human experience. It is disturbing because the isolation of children from adults simultaneously threatens the growth of the individual and the survival of society.”

The mass media

The Children and Parents report hits on another subject common to many reports, which emerged as a major Conference theme: the poor use of the mass media. It views television in particular as at present further isolating children from their mothers and fathers. Like several other forums, including one dealing specifically with the media, the Bronfenbrenner group urges new television programming for children. What is needed, it asserts, is programming “which no longer casts the viewer in the role of passive and isolated bystander, but which instead involves family members in activities with each other in games, conversation, and joint creative activity.” It finds “nothing inherent in television technology which precludes this possibility.”

This position is remarkably similar to the one taken by the separate forum concerned with the mass media, headed by Fred Rogers, creator and chief inhabitant of educational television’s “Mister Rogers’ Neighborhood.” “Hopefully,” the report of that forum states, “dialog between media producers, child guidance experts, and others will lead to programs that encourage active participation, interaction, and continuing dialog among different groups of the general public.”

The media forum’s prime proposal—which its report asserts “can and must be implemented immediately”—is for the creation of an Institute of Child Development and the Mass Media. The Institute, funded jointly by the Federal Government and the private sector, would bring together child develop-

Noel Epstein is a staff writer for the White House Conference on Children and Youth. Before taking this position in early 1970, he worked as a reporter and editor for the *Wall Street Journal* in Washington, D.C., and New York City.

ment specialists with program developers and other representatives of the media; award scholarships or fellowships, or both, to encourage the combined study of communications and child development; provide assistance for training community workers in the use of mass media materials; and issue studies on the effects of commercialism in children's programs.

Parent education

An equally striking media proposal comes from a separate forum report dealing with the "Emergence of Identity." This one, again reflecting the Conference's concern with parent education, proposes a "Sesame Street" type program for parents.

Led by Paul E. Torrance, chairman of the Department of Educational Psychology, Measurement and Research at the University of Georgia's College of Education, this forum comments:

"Although some parents intuitively meet the needs of their infants and children, many parents do not recognize the importance of their role in the development of their child's identity. And despite the essential nature of that parental role, the training of human beings for parenthood is left almost entirely to chance."

The television parent workshop it proposes would, "through high-impact, easy-to-understand techniques . . . assist parents with 'how-to' information and techniques on day-to-day child-rearing problems: playing with, stimulating, and teaching the young child; and developing an understanding of a basic child development theory."

The report includes a plan for carrying out this proposal, calling for formation of a steering committee and an advisory board; presentations for fundraising to business, industry, and private foundations; involvement of management and advertising firms; and the preparation of guides to production. "It has to be fun to watch, not talky, very visual, with a positive, upbeat image. If it ends up nicknamed 'that diaper-changing show,' we lose."

Similar concern for parent preparation is ex-

pressed in the Bronfenbrenner group's report. It calls for improved training for parenthood in the school by actually letting children care for other children.

"The best preparation for parenthood . . . is direct experience, under appropriate supervision Accordingly, from the elementary grades onward, children should be given the opportunity (not the 'duty' to engage in such activity. For example, an entire class might be invited to 'adopt' a kindergarten, day care group, or Head Start Center."

Advocacy for children

Throughout the Conference documents there also runs a strong appeal for Government actions. The need most frequently cited is for a system of advocacy for children. It appears in one report on child health in another on children and leisure time, and in several other papers, as well as in a forum report dealing exclusively with the advocacy question.

The advocacy plan is given its broadest and strongest expression in the report of a forum led by Judge James J. Delaney of the Colorado Juvenile and Family Court. As proposed by this forum, the advocate primarily would be the day-to-day protector in the community of the child's rights in nearly all areas of child concern. He would step in when the child's "liberty or health is jeopardized, whenever he is deprived of a home, schooling, medical care, proper rights, entitlements or benefits, or is subject to involuntary treatment."

Thus, if a child is severely beaten—an estimated 10,000 children each year are seriously abused by parents—the advocate might step in to get medical attention and possibly follow the case through until the parent is again deemed fit to manage the family. Parents in such cases often do not seek medical care for the child for fear of their actions being discovered.

If a child is suspended or expelled from school, the advocate might negotiate with the school on the child's behalf. If a child does not get proper medical care, he would strive to secure those services for him. The advocate and his staff of paraprofessionals would

The major recommendations and priorities for action adopted by vote of the delegates at the White House Conference on Children will be presented in the March–April 1971 issue of CHILDREN.

institute the single, central body working solely for the child in the community.

As proposed by the Delaney forum, the advocacy plan would involve a Federal-local system, as does the advocate plan proposed by the Joint Commission on Mental Health of Children. At the Federal level, the President would appoint a Council on Child Advocacy, which would direct the establishment of a Federal Office of the Child Advocate. The Office, among other things, would press for national legislation and strive to improve existing programs dealing with children. In effect, it would be seeking adoption of many of the other proposals of the Conference.

The Federal body also would develop guidelines for community or neighborhood councils on child advocacy. The local councils, which would represent all pertinent interests in the community, would employ the actual advocate and his staff.

While noting that "some specific and limited child advocacy now exists" on both the public and private level, the forum report maintains that "these services do not meet the day-to-day needs of the individual child in his own environment, nor are they designed to."

Health needs

The four forums dealing with children's health agree that the health care problem is so severe that the President and the Congress should immediately institute an advocacy system to safeguard all American children.

One group under the chairmanship of Donald C. Smith, M.D., professor of maternal and child health at the University of Michigan's School of Public Health, asserts that the implications for children of the seventies are "catastrophic" if the Nation does not develop a national health care program for them.

The forum chaired by Dr. Smith urges prompt creation of a national health insurance program for children. Citing various national health insurance proposals already under review in this country, the group says, "Our concern is not to evaluate the relative merits of any of the proposed programs." Its plan is advanced "within the context of a total family health care system. We are special pleaders only in the sense that we feel children should come first." Among the deficiencies in our current health care services, this forum cites:

- A death risk during the first year of life that is higher than that for any other age group under 65.

- An infant mortality rate that remains higher than that of 12 other developed nations and that is twice as high for American nonwhites as it is for whites.

- Delivery of mental health services to less than half of the children who need them.

- Health insurance that covers only 20 percent of the Nation's poor children.

- A system in which 21 million children under 17 do not see a physician even once a year and in which a million children are born to mothers who fail to get medical care during pregnancy.

- An accident rate that has taken the lives of more than 82,000 children since the 1960 White House Conference.

A health forum chaired by Morris Green, M. D., chairman of the Department of Pediatrics at the Indiana University School of Medicine, calls for the creation of child advocates at the national, State, and community levels to protect the health of children. The group sees these advocates as having generic training in pediatrics and backgrounds similar to maternal and child health officers, and as representing children's health needs in their localities.

Other proposals

Other forum reports also call for numerous Government actions. Among these:

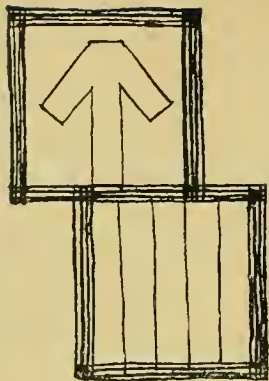
- Establishment of a federally financed system of "cultural vouchers" enabling children from 3 to 16 years old to purchase services that would foster the healthy growth of identity.

- Enactment of legislation guaranteeing the right to high-quality, comprehensive child care services.

- Making family planning services available to the poor as an essential element of comprehensive family care.

- Adoption of a federally financed income-support program geared to local costs of living.

The question now, of course, is what will become of the recommendations. It is impossible to know at this point. The one thing certain is that much will depend upon those 4,000 delegates who are now back home again. It has all just begun.



PLANNED VARIATION in HEAD START PROGRAMS

JENNY W. KLEIN

● Project Head Start was organized in 1965 to increase opportunities for preschool children of the poor by providing an environment in which each child has the opportunity to develop his full potential. As a comprehensive program, it offers such children a variety of services. Each local Head Start program must include the following components: Health, nutrition, education, psychological, and social services, parent involvement, and volunteer participation.¹ The emphasis Head Start has placed on the inclusion of activities in each of these areas has given substantial impetus to the development and application of innovative approaches to the delivery of services within each field.

In 1969 a major experimental program called planned variation, funded and coordinated by the Office of Child Development, was initiated within the framework of Head Start's education component. Designed to provide information about the impact of various preschool curricula on Head Start children, this experimental program should make a substantial contribution to the continuing effort to develop educational techniques for promoting the growth of all children, not only those who attend Head Start.

Although early childhood education is relatively new in this country, its value is now generally accepted. In addition, many people believe that early intervention in a child's life is an effective means by which to lessen or prevent later psychological, sociological, or educational problems. Various approaches to preschool education have been developed, tested, and presented in the literature in the last few years.²⁻⁷

There is lack of agreement, however, as to which methods are best suited to successful intervention.

The broad Federal guidelines governing the education component or "daily activities" of the Head Start program reflect recognition of both the value of early childhood education and the existing diversity of opinion concerning preschool curricula. There is no prescribed preschool curriculum for Head Start classrooms; nor does Head Start suggest that local programs adopt any "model" for the educational component. It places firm emphasis, however, on *good preschool practices* that provide children with opportunities to learn the skills appropriate to their age. In broad terms, it emphasizes the importance of giving a child ample opportunity to work and play independently, to learn to live effectively with himself and others, to develop a sense of identity, to experience many chances for success, and to sharpen and broaden intellectual, social, and physical skills. Thus, while following Federal guidelines, local Head Start programs may use a variety of methods to tailor their programs to the individual needs of their children and the community in which they live.

The planned variation experiment is an effort to explore the effects of several approaches to preschool education. A similar study is being made by Project Follow Through, a program designed to continue elementary schools the comprehensive compensatory educational efforts begun in Head Start. Coordinated with Follow Through, Head Start's planned variation program is expected to provide information about—

1. The effect of various well-defined education

strategies on children in Head Start.

2. The effect on the child of a continuous intervention program following the same educational strategy begun in Head Start and extended in the primary grades.

3. The lasting effect of specific program approaches. Can the rapid rate of development experienced in Head Start be maintained with all approaches?

4. The contribution of an intervention program in preschool in contrast to intervention in the primary grades.

5. The process of curriculum implementation. What does it take to initiate and carry out a new curriculum in a Head Start classroom?

Curricular models

The preschool curricular models or curricular approaches chosen for use in the study span the spectrum of current opinion in the field of early childhood education.^{8,9} Some of the models use a rather general approach; others are very specific. Some models are based on similar principles; others on quite divergent ones. For example, some place heaviest emphasis on the cognitive development of the child, on the assumption that training in this area will prevent later school failure. Others include the cognitive development of the child as only one part of their total program. Underlining the importance of the whole child, these curricular approaches take responsibility for the child's emotional, social, physical, and intellectual growth. Some models have been specifically designed for children from economically deprived families, stressing remediation, enrichment, and compensation. Others have been developed for preschool children in general.

The underlying philosophies of these curricula range from a psychodynamic approach to early childhood education to behaviorism and reinforcement theory. While some of the models are based on a belief that all learning must have a payoff and therefore provide children with tokens, raisins, or social reinforcement to reward correct responses, others are based on a theory that learning need not be externally motivated because it is intrinsically rewarding.

Several models are so similar in underlying philosophy that a classroom visitor might find it difficult to distinguish among them. Nevertheless, each model in the planned variation program has its own curricu-

ulum and characteristic way of implementing it. Some models use a structured classroom approach; others give children many choices of activities. Some models prescribe not only the content and structure of each day's activities, but also a detailed schedule that must be followed. Others provide objectives, guidelines, methods, and suggested activities from which the teacher can choose. Still others provide only materials and basic guidelines, suggesting that each teacher develop her program around the needs of her group. Thus, the role of the teacher varies from a didactic one, where she is directing all activities, to one where she structures the environment, provides learning experience and guidance, and observes the children as they choose their own activities.

All curricular approaches make some provision for children's play; however, in some of them play is only a tangential activity, while in others it is the core of the program. The latter are based on the assumption that preschool children learn best through play, direct experience, exploration, and experimentation.

Curriculum materials required by each model vary from automated teaching machines and formal programmed textbooks to a wide array of toys, books, manipulative materials, art supplies, and doll corner equipment.

Despite the differences among these curricular models, the research design of the planned variation study established some common prerequisites for inclusion in the experimental program.

- Each model must have been tested in a laboratory school and must represent a well-formulated strategy for preschool education.

- The sponsor of the model must be implementing a curricular program for elementary school children based on the model's principles, as part of the Follow Through program.

- The sponsor must be willing to work within the framework of Head Start and the overall research design.

A program sponsor refers to an individual, a group, a university, or an industrial firm that is responsible for the implementation of a specific curriculum. While the sponsor of the model may also be the same group or individual credited with its original development, this is not always so.

During the school year 1969-70—the pilot phase—eight curricular approaches, selected on the basis of

these criteria, constituted the planned variations in preschool educational strategy being studied by Head Start. A total of 1,750 children in Head Start programs in 16 communities were involved. As the planned variation experiment moved out of its pilot phase into its second operational year, its program was expanded by the inclusion of four more curricular models and the extension of the original models into additional classes in old and new communities. Today approximately 5,500 Head Start children in 37 communities are included in the 12 planned variations under study.

The following models are now part of the planned variation experiment:

The Bank Street College model, developed and sponsored by the Bank Street College of Education in New York City, represents a developmental approach in which the ultimate objective is to enable each child to become deeply involved and self-directed in his learning. Activities are planned both for groups and for individual children. The classroom is the child's workroom where he is free to investigate objects and explore materials. Opportunities for concrete, sensory, and motor activities are interrelated with opportunities for functional and expressive use of language.¹⁰

The behavior analysis model was developed and is sponsored by Donald Bushell of the University of Kansas. The goal of the program is to teach children needed skills by means of systematic reinforcement procedures. The teacher's role is that of a behavior modifier. Individual instruction is emphasized through the use of programed materials such as the Sullivan reading program (McGraw-Hill) and the Suppes mathematics program (Random House).

The academically-oriented preschool model is sponsored by Wesley Becker and Siegfried Engelmann of

the University of Oregon. Originally developed by Mr. Engelmann and Carl Bereiter, this model is premised on the belief that every child can achieve well academically if he receives adequate instruction and if there is a payoff for learning. The approach used is structured and academic. Programed materials are used to teach essential concepts and operation in reading, arithmetic, and language.

The cognitive model, developed and sponsored by David Weikart of the High Scope Educational Research Foundation, presents a cognitive-oriented preschool program derived from the theories of Piaget. The program has three main foci: (1) the curriculum, which is cognitively oriented—that is, the teacher plans activities that help children develop the ability to think about physical and logical relationships; (2) the teacher, who participates actively in developing classroom programs; and (3) the home, where the teacher works with the mother to promote cognitive growth in the children. Learning objectives are stated as behavioral goals.

A pragmatic action-oriented model, sponsored by the Education Development Center at Newton, Mass., was inspired by the English Infant Schools. The objectives of this model are (1) to provide a flexible curriculum and schedule; and (2) to fashion classroom environments responsive to the individual needs of children as well as to the talents and styles of each teacher.

The Institute for Developmental Studies model originated by Martin Deutsch, was one of the first models specifically designed for the education of disadvantaged preschool children. It emphasizes both the cognitive and affective development of young children. Specific areas of attention include concept formation, perception, language, self-image, and social-emotional growth. Instruction is individualized through classroom management techniques, continuous teaching assessment, and work through small groups.

The Florida parent-educator model, developed and sponsored by Ira Gordon of the University of Florida, uses both classroom and home instruction through parent-educators.¹¹ A parent-educator is a mother from the local community who works with the parents in their homes, presenting each with weekly tasks. These tasks are individualized for each child to develop cognitive skills. The parent-educators also assist in the classroom.

Jenny W. Klein, as senior education specialist for Project Head Start, has developed and helped execute the planned variation project described in this article. Before assuming her present position in 1969, she was a supervisor of special education in Montgomery County, Md., public schools, and a director of the MARC Schools for Retarded Children. She holds an Ed. D. degree from the University of Maryland and has been an instructor there as well as at George Washington University in Washington, D.C.

The primary education project model is developed and sponsored by the Learning Research and Development Center of the University of Pittsburgh. The most critical component of this model lies in an individual progress plan for each child, which allows the child to work through finely graded steps of curriculum at a rate and in a manner suited to his own needs. The curriculum emphasizes the basic skills and concepts the child needs to learn to master a variety of subjects.

The responsive model, designed by Glen Nimmiecht of the Far West Laboratory for Educational Research and Development, is focused on helping children develop both a positive self-image and intellectual ability. Emphasis is placed on increasing the child's sensory and perceptual acuity, language development, concept formation, problem solving, and abstract thinking. The child is encouraged to explore and find answers from responsive people, and responsive materials and equipment.

The Responsive Environment Corporation model uses specially designed learning materials and educational technology within a flexible classroom structure. The approach maintains a balance between structured and unstructured activities and emphasizes individual, independent work. The talking page learning system (a teaching machine that "reads" to children) is used for language development. Self-correcting sensorial learning materials are provided for learning basic concepts and developing abstract reasoning.

The Tucson early education model, designed by Marie Hughes, is sponsored by the University of Arizona. This model emphasizes the development of language competence, intellectual base, motivational base, and social arts and skills. The curriculum is carefully structured but is flexible enough to allow for choices in activity and behavior, thus providing the children with opportunities to develop individual skills at individual rates.

The enabler model, designed by the National Head Start Office, emphasizes consistent technical assistance, rather than a specific curriculum. During monthly visits to the local Head Start programs, an early childhood educator first helps the program's staff and the children's parents formulate program goals and then develops means of attaining them.

Since this model requires no specific curricular methods, the consultant's records serve as documentation of the techniques being used.

Implementation and evaluation

Each program sponsor in the planned variation experiment receives funds from the National Head Start Office to carry out his curricular approach in Head Start centers in several communities. The sponsors carry full responsibility for directing all educational activity in the designated Head Start programs. Working within the framework of the National Head Start guidelines and the demands of the local situation, the sponsors train the teaching staff, equip the classrooms, and follow whatever other procedures they deem necessary to insure that their model is being correctly implemented. Techniques for setting up their programs vary, as do their curricular approaches.

Several considerations went into the selection of the sites for applying the particular models in the planned variation experiment—the existence of an appropriate Follow Through program, the type of community in which the Head Start program was operating, the willingness of the parents and staff of the local Head Start program and other members of the community to participate in the experiment.

Thus, the research design limited the experiment

Play and learning go together in this Head Start center. In some programs play is tangential; in others it is the core.



to communities with Follow Through programs in which children could experience the same curricular approach in their early years of elementary school as they had had in Head Start. For example, a local Head Start program could be considered as a site for carrying out the Bank Street curriculum only if a large proportion of the children enrolled would subsequently be attending an elementary school where the Follow Through program was using the Bank Street model.

The type of community was taken into consideration and an effort was made to include a wide variety by situating the models in urban, rural, and various subcultural and geographic settings.

Staff members of Project Head Start's national and regional offices, and the model sponsors made preliminary selection of communities and visited local Head Start programs. In each community, they briefed Head Start parents and staff on the implications of participation in the planned variation program. Particular attention was paid to explaining the model—its goals for children, its methods of operation, and what would be expected of parents and staff. The final decision to take part in the experimental program was then made by the local Parent Advisory Council, Community Action Agency, and Head Start staff.

Evaluation of the planned variation experiment, designed by Lois-ellin Datta of the Office of Child Development, is being conducted by the Stanford Research Institute, which is also responsible for Follow Through evaluation. The research design includes a variety of measures for assessing the implementation of the sponsor's program, classroom processes, family variables in the participating families—such as status and family dynamics, and the children's cognitive and affective development. The development of children and their families participating in the various models will be compared with the development of (1) children and their families who are enrolled in regular Head Start programs, and (2) children in low-income and middle-class comparison groups who have not had a Head Start experience.¹²

In line with the Head Start policy of employing residents of its target areas, much of the testing, interviewing, and observation is now being done by people in Head Start neighborhoods who have been trained by the Stanford Research Institute for this purpose.

The planned variation study begins when the children enter Head Start and will continue through

their Follow Through experience through third grade. Interim reports on the experiment will be prepared at the end of every year.¹³ The final report, however, will not be available until all parts of the study have been completed and all the data analyzed.

Some early effects

The planned variation experiment has already had some noticeable effects on the field of early childhood education, particularly through its emphasis on sequential education beginning at the preschool level and on the availability of a variety of preschool curricula. Recognition of the importance of sequential programming for children is stimulating public schools, Head Start centers, and nursery schools to begin coordinating their programs. Head Start programs and other preschool groups have also been influenced by exposure to the planned variation design to explore the possibility of adopting new curricula—formally or informally—in toto or in part.

This "ripple effect" will undoubtedly continue as the research data gathered in planned variation classrooms furnish new insights into the education of young children.

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BRIDGING THE CONCEPT GAP IN WORK WITH

YOUTH

ALBERT S. ALISSI

● So many concepts of adolescent behavior exist today that anyone who works directly with young people needs to get his own view of a perspective, understand the various other vantage points from which he might view his subject, and take into account the young people's own attitudes and beliefs.

Implicit in many efforts by adults to understand and deal constructively with adolescents in modern society is the concept that most of the problems associated with this period of life would somehow disappear if only it were possible to "bridge the generation gap"—the break in the continuity of life styles between one generation and the next. This bridging concept suggests that the ideal relationship between the generations should be one of consensus and harmony, and further, that the major responsibility for creating such consensus and harmony depends in some way on the purposeful actions of members of the older generation. Accordingly, parents, teachers, counselors, social workers, and an entire army of youth workers who have already achieved full status as adults feel called upon to create the conditions for bridging the gap. Indeed, wherever the gap persists, society directly or indirectly holds adults to account.

A society undergoing social and cultural change—such as our own—necessarily exhibits stresses and strains that result in intergenerational tensions.

From an adult perspective, members of the older generation have a key role in the socialization process that perpetuates their cherished values, knowledge, and skills and makes these attributes available

to the younger generation. Such a concept implies the maintenance of a smooth functioning social system that is relatively free from disruption. Accordingly, adults who believe that an established order is essential to society's well-being see the rebellion of young people as a threat. However, rebellion also may be interpreted as a beneficial sign of growth and development in the adolescent who, in the process, adds meaning to his life through the assertion of his own self-identity. Unfortunately, this basic dynamic of intergenerational relations is not widely understood.

From the adolescent's perspective, the older generation has to make room for every young person economically, politically, and emotionally if the young person is to realize his potentialities.

Concepts of adolescence

Adolescence has been defined as an intermediate stage between childhood and adulthood in which there is accelerated physical and psychological growth. Anna Freud has described the emotional aspects of adolescence in this way:

Adolescents are excessively egoistic, regarding themselves as the center of the universe and the sole object of interest; and yet at no time in later life are they capable of so much self-sacrifice and devotion. They form the most passionate love-relations, only to break them off as abruptly as they began them. On the one hand they throw themselves enthusiastically into the life of the community and, on the other hand, they have an overpowering longing for solitude. They oscillate between blind submission to some self-chosen leader and defiant rebellion against any and every authority. They are selfish and

materially minded and at the same time full of lofty idealism. They are ascetic but will suddenly plunge into instinctual indulgence of the most primitive character. At times their behavior to other people is rough and inconsiderate, yet they themselves are extremely touchy. Their moods veer between light-hearted optimism and the blackest pessimism. Sometimes they will work with indefatigable enthusiasm and at other times they are sluggish and apathetic.¹

Another concept of adolescence looks beyond the individual to the social aspects of the adolescent's behavior. This sociological perspective sees adolescence as an unstructured and ill-defined phase of life lying between childhood and adulthood. In this perspective adolescence is characterized by "crises in discontinuity of statuses," creating what has been described by Hans Sebald as "a poorly structured no man's land."²

An adult cannot deal adequately with the adolescent unless he recognizes that the adolescent experience has physical, psychological, social, and cultural dimensions. Although it is useful to isolate one dimension for analytical purposes, such emphasis can be misleading. The adolescent experience is best understood when it is seen as part of a larger functioning whole.

Viewing adolescence not only as a distinct entity but also as a psychosocial phenomenon in interaction with other social phenomena may help explain the paradoxical nature of some adolescent behavior. Close examination may reveal that a difference in responses depends upon the context in which the young person finds himself. For example, in relation to adults, the adolescent may be confused, uncertain, and vague; in relation to his peer group, the same adolescent may be clearly motivated and precise—an accomplished member of a subculture who has found role security. In the sociological view, then, every analysis and every interpretation requires that the interrelationships of the adolescent and various groups be considered simultaneously.

What adults perceive or overlook in their attempts to make sense out of adolescent behavior is influenced by their own concepts. For example, if an adolescent displays fear and anxiety, the psychoanalytically oriented professional person may interpret these reactions as the outcome of libidinal impulses being turned against the self. On the other hand a sociologically oriented professional may interpret the same adolescent's anxiety as reflecting a state of normlessness or anomie that stems from the social structure. Cultural goals, institutionalized means, status deprivation, role confusion, and similar concepts are at

hand to explain the behavior. Inasmuch as any analysis is influenced by the frame of reference used, the responsible youth worker has to be conscious of his own perspective.

For some time the behavioral sciences have been engaged in a frustrating search for concepts that in effect will integrate both psychological and sociological explanations of behavior. Until such integration is possible, there remains the danger of forcing the data to fit the concepts developed within an isolated, narrow context. Moreover, sometimes concepts originally designed to explain particular phenomena are erroneously applied to different, unrelated phenomena.

The nature of the diverging concepts is perhaps best illustrated by ideas identified with the psychological and sociological frameworks utilized by professional persons who deal with adolescents.

Psychoanalytic view

Psychoanalytic theory, due largely to its pervasiveness in American professional thought, is a rich source of concepts for youth workers. The classic psychoanalytic view of adolescence emphasizes the changes during puberty upset a balance established during the preadolescent years between the ego, the conscious self, and the id, or unconscious drives. The resurging oedipal complex in early adolescence brings with it derivatives of primal impulses and aggressive drives. The adolescent struggles to free himself from such incestuous impulses, an action that leads to rejection, resentment, and hostility toward parents and other authorities. In the psychoanalytic view confused behavior at adolescence is an external indication of adjustments taking place internally and is a sign of normal growth. Conversely a steady equilibrium during adolescence suggests abnormality.³

This orthodox psychoanalytic position has been modified by Erikson, Fromm, Horney, Sullivan, Bettelheim, and others who emphasize the role of social factors in the developmental process. In respect to the generation gap, attempts to understand the adolescent solely in psychological terms are inadequate. As Bruno Bettelheim has pointed out, "the problem of generations is at best a psychosocial one, and can never be dealt with on a purely psychological basis."⁴

Furthermore, Erikson has observed that identity formation, while critical to young people, is really a generational issue.⁵ His concept of ego identity

presents the search for an inner continuity that matches the outer social circumstances.⁶ The term "identity crisis" has taken on a normative meaning when applied to adolescence. "Crisis" does not connote impending catastrophe, but rather a necessary turning point at a "crucial moment" when development must move one way or another in "managing resources of growth recovery and further differentiation."⁵

In the main, the identity concept concentrates on the fusion of a variety of elements—such as identification, capacities, opportunities, and ideals—into a stable self-definition. Adolescents vary in the tempo at which they find an identity. Some crystalize identity early and so avoid diffusion; others, who do not seem to find themselves, try out various identities and exist in a kind of "psychosocial moratorium."

social perspectives

A different view focuses on the social and cultural determinants that in a sense create the adolescent condition. The unstructured or ill-defined social position so characteristic of adolescence stems largely from two factors in society: a division of labor that requires complex technical skills; and the failure of the cultural system to provide a meaningful ideology that gives the young person a strong sense of identity and feeling of purpose. The emotional instability and general turbulence associated with adolescence arise then out of the indeterminate status of the adolescent in the social structure rather than from innate constitutional causes.²

Unless the social and cultural systems are altered, instability will continue to be the normal state of adolescence, according to this view. Young people in industrialized nations find it difficult to develop stability because they seldom receive recognition for their actual or potential contributions to society and they frequently are denied opportunities to take a significant role. The *komsomols* of Soviet Russia and the *kibbutzim* of Israel are exceptions, as were the Nazi youth organizations.

However, instability in adolescence, producing social and cultural unrest, is much more symptomatic of a modern industrially developed society. For example, England has its teddy boys, Rockers, and Mods; Russia, its *stilyagi*; Japan, its thunder boys; France and Germany, their Americanized teenagers and hippies. Societies now in the process of industrialization can be expected to create their own adolescent phenomena in the future.

A somewhat different view sees society as manipulating the adolescent into patterns of mass conformity. Society "dampens out" questioning, conflict, rebellion, and all other stress for the adolescent. Because he does not experience the stress and strain usually related to growing up, he is deprived of the opportunity to establish his real identity. Therefore, adolescence, being minimized as a developmental phenomenon, is vanishing.⁷

Some adolescents refuse to conform. Youthful protesters who have made deep commitments to changing current social and environmental patterns can be seen as a reminder that idealism is not dead, "but entrusted afresh to each new generation."⁸ On the other hand, the new alienation has been interpreted as a form of rebellion without a cause, of rejection without a program, of refusal without a vision.⁹

Some professional youth workers interpret the role of the youth culture, or peer group, as essential in helping its members achieve full adult status. According to one view, the training that the adolescent receives from his family is not adequate for developing full identity and social maturity. With help from a group of young people of his own age, however, the adolescent is able to make the transition from the "particularism" of the family to the "universalism" of the larger society.¹⁰

Another perspective sees the adolescent subculture as fast becoming a distinctive life style with a language and value system of its own. This perspective suggests that society is no longer confronted with a set of individuals to be socialized into adulthood, but instead is faced with an adolescent social system that offers a united front almost impervious to adult intervention.^{11, 12}

Practical implications

The failure to integrate these psychological and sociological perspectives has intensified isolated attempts to interpret and understand adolescence. For workers who are pressed to serve young people in meaningful ways, this lack of an integrated base of knowledge that realistically depicts the totality of man's existence is a severe handicap. Specific practices and techniques used by youth workers correspond to and are influenced by the views that prevail in the various professions. Teachers, guidance workers, social workers, recreational specialists, and other adults interpret adolescent behavior in ways consistent with the goals and objectives of their own professions. Furthermore, the adoption of specific

concepts often leads to the application of predetermined practices and skills.

For example, educationally sound principles constitute the conceptual framework in which teaching techniques are developed. Ideally, teachers see the adolescent as an individual to be guided in intellectual growth. Such teachers handle classroom problems with tried and accepted methods. Their success is measured in the learning that takes place among their pupils.

In contrast, the more radical techniques of the free-floating neighborhood gang worker stem from another set of predetermined concepts. He sees the adolescent as an integral member of a group of peers reacting to a hostile social setting in which opportunities are limited and the future holds little promise. The worker's success may be measured by the lessening of group conflicts, the establishment of "healthier" attitudes, and the curbing of delinquent activities.

The problem of integrating viewpoints also exists within the helping professions. For example, the three major methods of social work—casework, group work, and community organization—are focused on the individual, the small group, and the community, respectively. Everything that has been said about adolescence has implications for providing service that is much broader than any one of these categories.

Specialized approaches reflect selective biases regarding what the real world is all about. Problems in real life, however, do not fit neatly into schemes for categorizing and understanding them. In spite of the competing claims made on behalf of various concepts, no single model for interpreting behavior accurately reflects the totality of life experience based on complete knowledge. Those who work with young people are nevertheless expected to mobilize resources and give service as if such a body of knowl-

edge were in fact available. Methods and techniques designed to meet the complicated requirements of adolescence are based only on selected aspects of the total reality, and their range of usefulness is essentially limited.

Yet, in time these methods take on importance far out of proportion to their original worth. The methods, skills, and practices themselves become institutionalized, no longer acting as means to an end but serving as ends in themselves.

Furthermore, specialized approaches are gradually incorporated into organizational routine and, in the process, the search for alternative solutions tends to be discouraged. Even worse, the problems themselves are often neglected as they are modified and manipulated into ready-made molds and predetermined methods.

Illustrations

Two illustrations from social work practice form the basis for discussion of concepts already described. The first, which deals with efforts to help black adolescents, reveals how workers who hold an exclusive perspective have in a sense predetermined the method to be applied. The second illustration, an unusual incident in a multiservice neighborhood center, points up the complicated problem of coordinating practices among workers from various professions and services.

1. During a time of racial strife and rioting in a large city, a group of black militants organized neighborhood training centers to teach younger blacks how to make molotov cocktails. The militants recruit adolescents on their way to public high schools.

How should the situation have been handled?

On the one hand, this problem may be conceived in terms of an individual adolescent who at a specific stage in his development is skipping school and succumbing to dangerous environmental influences. On the other hand, it may be viewed as a community problem in which a deviant subculture is threatening young people.

Where the focus is on individual pathology as revealed by the adolescent's inability to withstand pressure from the militants, the approach is oriented toward treatment of the adolescent; where the focus is on social processes, the approach is an attack on poorly integrated social and cultural systems.

By adopting concepts predominantly related to the young person and his individual level of function

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g at a specific stage of development, the worker focuses his attention on the adolescent himself. Thus the adolescent's struggle to resolve his own identity crisis becomes important. The worker assesses both the current situation and the social history in terms of the adolescent's needs, problems, and strengths: the increase in instinctual demands of the ego, rejection of parents and other authorities, inadequate adult models within the family, the black militant model, use of fire bombs as a form of violence, identification with the civil rights movement, and guilt over skipping school.

Attempts to lessen pressures of reality would be made largely through helping the adolescent learn to cope with such pressures. Therapeutic goals might include supportive help, setting limits for the young person, dealing with his resistance in a constructive way, transference of his allegiance from militants to other models, and dealing with countertransferences. Parents would be included in the treatment.

When approaching the problem from a social-cultural perspective, the worker would view the emergence of a deviant form of activity as the subculture's response to what it considers intolerable conditions. Thus the black militants' program provides an ideology that the adolescent finds stimulating, exciting, well-defined, and unambiguous. Youth-service programs fashioned on the traditional mental hygiene model stand little chance of appealing to adolescents against such competition.

This view of the problem inevitably leads to a consideration of peer group influences, the degree to which the youth culture is integrated with segments of the adult community, the kinds of opportunities available to minority-youth groups, and so on. Practical new programs using successful black persons as street workers would link the adolescent group to the more stable adult society and to opportunities such as those offered by the Neighborhood Youth Corps and special training programs. Dealing with adolescents as they interact with one another and with adults challenges the worker to use informal group methods, learn the jargon of the peer group, and develop significant links between and among various neighborhood groups.

2. As previously mentioned, a major problem in the coordination of services at all levels of practice is the lack of an integrated set of concepts. Even when efforts to coordinate are most sophisticated, the final outcome often is fragmented services and a confused client, as the following example shows.

A multiservice community-based agency carefully organized its programs to provide a variety of professional services. Among its clients was an adolescent boy suffering from the inability to relate to others in his peer group. The boy desperately sought to obtain acceptance from other boys through boasting and fantasizing. The agency therapist worked intensively with him and his family to help him deal more realistically with his problems.

The crisis came during a period of innercity rioting, when some adolescents formed self-appointed vigilante groups to protect the neighborhood from imaginary invaders. As one of the participants, the boy obtained a rifle. In his clumsiness he accidentally shot himself, inflicting a minor wound. He quickly covered up his own inadequacies by boasting to the other boys that he had been shot in an encounter with an "invader." Reports of this imaginary incident spread quickly, creating anxiety, fear, and irrational behavior among residents of the neighborhood. In the panic that followed, an innocent bystander was shot.

While this example involves an extreme case, it illustrates how knowledge in one area of practice failed to complement the work in another area—even where coordinated services existed. The focuses of the therapist and the community workers dealing with the boy were essentially different and in effect bypassed each other. Although the therapist might have predicted some type of irrational behavior on the boy's part, the agency had no means for communicating such a prediction to other workers or for dealing constructively with the problem.

Synthesizing concepts

How can diverging concepts be brought together into more meaningful forms of practice? A conscious effort to integrate concepts into practice could lead to changing perspectives in some areas. Most essential to the process is the identification of the basic assumptions, implicit and explicit, upon which any service rests. Because unrecognized assumptions serve as cultural blinders, they tend to block new and unique practices.

As previously indicated, the bridging of the generation gap calls for the creation of stable conditions that permit both adults and adolescents to work out tensions and provide the adolescents with the opportunity to gain new status. A step toward synthesizing concepts would be achieved by accepting certain core themes in this regard. For example, if

the concept involves the provision of newly created places in society for young people, youth workers could go outside the traditional boundaries of behavioral sciences to coordinate what is known about the identity crisis with knowledge of the social structure. Instead of treating individual pathology or manipulating social systems, the workers would use knowledge of the social structure to help the adolescent. The focus would be on finding ways to help adolescents search out their individual potential, encourage them to become actively engaged with other adolescents and with adults, and create a meaningful period of transition for young people in the society.

One cannot overemphasize the need to view adolescents and adults as an interacting unit; individually each represents only a part of the total reality. As the interaction of the two becomes the basic unit of concern, new guides for bridging the generation gap will be developed.

To apply this concept, agencies would redirect their activities at those points in everyday life at which young people and adults come together. Such action would call for a revision of most educational programs, youth-service agencies, and neighborhood and community centers. Without interfering with peer associations, both adults and young people could be given a share of responsibility for schools, agency centers, and economic and political activities. As the adolescent becomes a contributing member of his environment with new structured positions in decision-making groups and well-defined expectations for responsibility in service projects and economic enterprises, his involvement in things that matter would be greatly expanded.

At the same time, part of the emphasis would be on encouraging adults to accept adolescent upheavals as "natural" social events. In concrete terms, changing traditional attitudes may require educational programs aimed at overcoming negative reactions, both of adults and teenagers, that strain intergenerational relations and cloud the real issues. Conflicts would be institutionalized through new opportuni-

ties for community debate and shared problem-solving activities in arenas where community standards influence the behavior of young people. In his search for an individual solution to the identity problem the adolescent would be encouraged to invent significant roles for himself in dealing with vital issues.

The dual emphasis on interaction between young people and adults may lead away from overspecialized services aimed at particular age groups. As becomes apparent that success depends on skill in influencing the nature of the *interactions* between the younger and older generations, those who work with people may become less identified with a specific age group.

Admittedly, it is difficult to project a clear picture of services reorganized around different sets of concepts. Even as familiar programs and traditional ways of thinking about them become outmoded or ineffective, they continue to influence judgment, blocking easy access to new insight and fresh approaches to current problems.

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AN ATTACK ON IMPEDIMENTS TO EFFECTIVE CROSS-CULTURAL TEACHING

LAMORE J. CARTER • OLIVER D. HENSLEY

A little over a year ago, a 10-year-old black, deaf child in Monroe, La., had never attended school, had never played group games with other children, had seldom ventured from his home, and could not utter a distinguishable sound. Today, however, he speaks haltingly, "hears" through lip-reading techniques, shares the excitement of classroom games, and is engaged in learning activities that allow him to achieve continued academic progress and self-satisfaction.

What accounts for this change? The answer, in a sense, is simply, "He was given the opportunity to learn." But the question still remains: How did that happen? Of course, forces may promote immediate change and it is often difficult to identify the exact source that initiated the change process. However, certain college and public school people in Arkansas, Louisiana, and Mississippi think that at least part of the answer to this question lies in a model for inservice training devised at Northeast Louisiana University. The success of Project LIFT (Laboratory Institute to Facilitate Teaching), a significant departure from traditional inservice training programs, leads these educators to believe that they can gain acceptance of and support for educational changes by the whole community if they train action research committees to devise and install preplanned changes in the public schools.

Project development

LIFT initiated a long series of unprecedented activities in the early part of 1968, when black educators and white educators from the Ark-La-Miss

region met to formulate plans to produce biracial cadres of professional educators who would attempt to bring better educational programs for all children to their local communities.

The multistate and biracial approach to solving problems was a new and exciting experience for these educators. Sometimes the initial meetings of the principals for planning activities were awkward and filled with suspicion. In some instances, administrators of colleges less than 50 miles apart had never received an official visit from each other to discuss the pooling of resources to solve critical regional problems. The cooperative planning of many colleges, both black and white, with public school officials opened a whole new communication system based on interpersonal patterns that are now used with increasing frequency.

The goal of these early designers of LIFT was to retrain 96 teachers who had been assigned to racially integrated schools to use new teaching strategies and to innovate curriculum projects for improving instruction for every disadvantaged child. The project was funded by the U.S. Office of Education under the Education Professions Development Act in the latter part of 1968. It started the first of its four distinct stages of development in January 1969.

The first step, the awareness stage, was designed to sensitize the participants to the special needs of the disadvantaged child in their schools and to acquaint them with the resources that could help them meet his needs.

The second step, the design stage, was planned to encourage local civic leaders, action research committees, consultants, and neighborhood school repre-

sentatives to design special programs needed in their own specific areas.

The third step, the laboratory stage, was designed for trying out the plans. The participants spent 6 weeks in a pilot school where their plans were given a trial run in classes attended by disadvantaged children. After assessing the effectiveness of their designs, the action research committees revised their programs and applied them in their local schools during a semester of extensive field testing.

The last step, the demonstration stage, gave educators and lay people in the area an opportunity to see selected new programs operating successfully in integrated schools in their home district. The Project LIFT participants conducted tours of their new programs for parents and teachers when school was in regular session.

During the 18-month operation of LIFT, the participants and staff shared many successes. They also suffered a number of frustrations as they ran headlong into a long-established way of life.

Some problems

One of the first problems encountered by LIFT was the antagonistic attitude of news media and conservative politicians. After the first LIFT meeting, the local newspaper printed the inflammatory headline, "Plight of Negro Blamed on Whites," over a story of an interview with a LIFT speaker. This created a great deal of controversy in the community and provoked numerous hostile phone calls to the college by persons bent on finding out who was "stirring up trouble." Politicians misquoted LIFT speakers and distorted the philosophy of the program in the newspaper, on radio and TV, and at meetings of business, civic, and social organizations. They continuously condemned the project and asked for "public repudiation of insidious statements" and "an end to this outrage." Political pressure was applied to State commissioners and school officials "to end the misappropriation of the taxpayers' money to such ill-advised projects."

Quickly LIFT's staff and participants started for the first time to work for a change of the news media's attitude toward the project. Black and white editors, radio and television personalities, and politicians were brought as guests to LIFT seminars where they became involved in helping the participants devise strategies to enlist the aid of journalists in promoting educational change.

After several exposures to LIFT's philosophy participants, and additional information about the project, the attitudes of key people in the news media changed from negative to very positive. Feature stories, TV specials, and radio interviews highly supportive of LIFT began to attack the basic reason that new programs were not being developed in the schools. While LIFT did not drastically change the beliefs, attitudes, and values of all news people in this area, it did convince the influencers that the program would benefit the community and that they should support needed local educational programs and LIFT activities. As the news media became more supportive, the community at large became more receptive to proposed educational changes.

The most persistent problem for Project LIFT was racial prejudice. In almost every suggestion for change in the local schools, the often unspoken, but unyielding, resistance that prevented change was directly connected with opposition to promoting further racial integration. This resistance was evident in the awareness phase of LIFT as some of the participants openly opposed the program's basic philosophy of upgrading education for disadvantaged children in integrated schools. The concept of biracial teams working on common tasks was also repugnant to some of the participants, and soon dropped out of the program after the first two meetings because they could not work with people of the opposite race.

Perception deficits

One of the authors of this article, Lamore Carter, functioned as LIFT's consulting psychologist. He identified the major problem in the area of attitude change for teachers working in an integrated school as the "Thing" and "Halo" phenomena, which he defines as follows:

1. The "Thing" phenomenon is the relative inability of most white Americans to perceive and accept black Americans without some prejudice based on imagined deficits.
2. The "Halo" phenomenon is the relative inability of most black Americans to perceive and accept white Americans except as persons fundamentally competent, "better," more knowing, and less likely to have faults.

In an address to the 96 LIFT participants, Dr. Carter described how these phenomena impede teaching

"It is the 'Thing' phenomenon that makes it difficult or impossible for a white teacher, pupil, or school administrator in traditional educational environments to view and accept a black teacher, pupil, or school administrator as a person with no more than the usual human frailties. There is the constant and forceful expectation on the part of the white educators that some significant deficit of professional competence, personality, or character will be discerned in the black educator. Under such circumstances, the expectation is almost always confirmed, because the white teacher, administrator, or pupil is subconsciously searching for negative factors and has a limitless range of choices. . . .

"It is the 'Halo' phenomenon that makes black teachers, pupils, and school administrators look for more competence, perfection of personality and character in white teachers, pupils, and school administrators and find it when it is not there."

The discrepancy in perception represented by the "Thing" and "Halo" phenomena is due primarily to the cultural experiences that condition both blacks and whites to regard a wide range of behavior of whites as acceptable and natural in whites, and, at the same time, to regard similar behavior in blacks as artificial and imitative.

At first, participants tended to divide along racial lines and to come to the LIFT meetings as separate black or white units from their schools although their superintendents had told them to function as a single unit. Several months later, after they had been immersed in biracial work-study tasks and exposed to seminar leaders from various races, disciplines, and nations who specifically planned programs to make the participants more openminded, they voluntarily began to ride together and had apparently shed much of their traditional bias. These cognitive-affective benefits in LIFT participants were reduced by having

black teachers and white teachers work together on practical problems existing in their schools.

Project LIFT assaulted another misconception. Prior to 1969, no summer school for elementary children had operated in the Ark-La-Miss area. The excuse for not supplying such opportunities was that disadvantaged children did not like school and would not attend if a school were opened. LIFT, with the excellent assistance of a courageous superintendent, opened a laboratory school that accommodated 200 disadvantaged students for 6 weeks. Many more children applied for admittance but had to be refused because of the lack of facilities. In 1970, several school districts on their own opened summer school programs for disadvantaged students and for the first time provided remedial programs for children with severe learning handicaps.

Demonstration stage

The shedding of myths and misconceptions, a major goal in the awareness and laboratory stages of project LIFT, was in a sense actually a means to another end—bringing about educational progress in the schools.

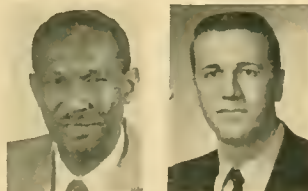
The laboratory phase of project LIFT provided the resources for teachers and community leaders to plan an attack on specific problems in their local areas. The effectiveness of their planning activities was tested in the demonstration stage. At this stage LIFT's staff and participants had the obligation to establish in local integrated schools demonstrations of innovative educational programs.

Bobbie Bowie, a teacher in Monroe, La., fulfilled her obligation by developing a program for teaching deaf children to lip read, to learn to speak through the EFI (Electronic Futures Incorporated) training system, and to work with materials and participate in social activities specifically designed to help them. Benjamin Boyte, a teacher in Concordia Parish, designed and conducted a course in drama to effect better verbal communication between students in an integrated all-boys high school. Last spring, his course was adopted in several schools in Arkansas.

A new approach to teaching science was initiated by Madolyn Abraham in Bossier City, La. She used the discovery method of teaching, relying on field exercises instead of textbooks or workbooks. She also helped black students and white students adjust to one another by assigning research projects to racially integrated groups as well as to individuals.

Elsie Warnock, a junior high school teacher in El

Amore J. Carter, Ph. D., (left) is presently dean of cultures, and professor of psychology and education, Texas Southern University, Houston. He was formerly distinguished visiting professor of psychology, Morehouse College. Oliver D. Hensley, Ph. D., is director of research and projects at Northeast Louisiana University and also of Ark-La-Miss Research and Development Center for Education.



Dorado, Ark., attacked the problem of apathy and absenteeism in poor readers of both races. She gave both individual and small group assignments, using books and other kinds of materials, reading machines, pacers, and tachistoscopes (a mechanical device that flashes a specific number of words on a screen for a governed period of time). Her students increased their academic achievement significantly, and as a result she found that their attitudes toward school had improved.

Two administrators, Ernest Choyce and Loyce Nute, initiated a special program for retraining 38 elementary school teachers in Morehouse Parish, La. They also converted a traditional academic program into an individualized program that rewards students for achievement.

Linda Bourgeois, a special education teacher in Vicksburg, Miss., initiated a success-oriented program to produce positive self-concepts in handicapped students by demonstrating techniques for teaching students to acquire feelings of pride of accomplishment and heightened aspiration levels. She was particularly successful in changing the attitudes of her colleagues toward children needing special education.

The Action Research Committee in Lake Village, Ark., consisting of several LIFT participants, instituted for all the teachers in the public school system an elaborate inservice training program to investigate problems related to school desegregation.

Joan Minor, language arts teacher in Vicksburg, Miss., constructed a black studies program for the sixth grade that provided special packets of materials to help black students and white students learn about Negro culture. In addition to using materials she prepared herself, she assigned her class group projects to collect contemporary information about Negro culture.

Sue Breland, a special education teacher at J. B. Cooley Hospital in West Monroe, La., instituted a special program for mentally handicapped children from economically disadvantaged families. The 15 children in her class practiced basic social, academic, and physical skills and thereby improved both their emotional and physical fitness.

Each of these demonstration projects has its own story. Each participant approached a problem differently and planned a unique attack. Each program now stands on its own base and is vigorously engaged in promoting better education for the disadvantaged. Project LIFT is no longer in existence, but through such demonstrations, the scope of its influence has widened and its spirit is continuing.

Major outcomes

Behind each of the purposes of Project LIFT was the necessity for changing the way black and white teachers, pupils, administrators, and nonschool people look upon one another. Faulty interpersonal perception generates negative interpersonal interaction. Such a project starts with candid acknowledgment that the pressing needs of our time demand that each person (teacher, administrator, pupil, parent, or citizen) cooperate to produce a learning environment free of impediments for all America's children.

Today, a significant number of black teachers and white teachers are effectively teaching black children and white children together, and experiencing commendably harmonious relationships in schools of the Ark-La-Miss region. Some say it is a "great pretense that will soon blow up in the form of interracial squabbles. However, some very fruitful results have already accrued. It is now the responsibility of the participants to continue the promotion of good teaching in integrated schools.

Childhood is the form that upholds each child's life forever. If a man or a society taints a child's childhood, brutalizes it, strikes it down, and corrupts it with fear and bad dreams, then he maims that child forever and the judgment on that man and that society will be terrible and eternal.

Ned O'Gorman, "The Storefront," Harper & Row, New York, N.Y. 1970

VOLUNTEERING TO HELP INDIANS HELP THEMSELVES

EDMUND DIMOCK • BARBARA RIEGEL

Discontent over the plight of a neglected Indian tribe has prompted a group of social workers in San Diego County, Calif., to organize our own volunteer project to do something about it. Aided by other volunteers, we have developed a number of activities to resolve some of the educational and economic problems of the Indians who live on the Viejas Reservation in a rural area of the county 30 miles east of San Diego. The activities—at first resisted by the Indians themselves, but now enthusiastically welcomed—consist of a tutoring project for schoolage children, delivery of food commodities to the elderly and handicapped, and improvement of communication between the Indian and the white communities. We think that through our project we have demonstrated the considerable impact on social problems that professionals can make by volunteering their skills.

The Viejas Reservation is one of 19 Indian reservations in the county. In common with other reservations, its water supply and sewer facilities are inadequate, its housing is substandard, and it is not served by public transportation. Indians were moved to the Viejas Reservation in the 1930's when their original lands were sold to San Diego for a reservoir. Most of the small, unpainted wooden houses were built at that time; now they are in disrepair.

There is electricity in most of the houses, however.

About 30 families with 50 children live on the Viejas Reservation. The younger children attend elementary school 5 miles away in Alpine; it has eight grades and an enrollment of 700. The high school, with an enrollment of 1,800 students, is 15 miles away in Lakeside. For many years these schools made little attempt to interest or retain the Indian students; they did not teach Indian culture until 1970-71. The dropout rate among the Indians who enter high school in this area is more than 80 percent.

A number of adults from the reservation work in San Diego or in nearby communities because there are no jobs on the reservation. The reservation church offers no social or cultural activities for the Indians, but some integrated cultural and recreational groups in Alpine are open to them.

The deplorable housing conditions on the Viejas Reservation and the others in the county are a result of many years of inadequate budgets for the Bureau of Indian Affairs. Moreover, BIA does not provide social or health services on these small reservations. The only social services are given by social workers from the county department of public welfare, who maintain regular contact with recipients of public assistance, and the school nurses, who provide health services for children at the elementary and high

schools. The nurses seldom visit the reservation, however.

Our involvement with the Indians started in April 1969 when 12 of us, members of the California Social Workers Organization, formed an ad hoc committee to help the people of Viejas Reservation deal with problems that we had become aware of through our experiences with Indian recipients of public assistance.

We realized that we could not satisfy such major needs as housing and sanitation. All of us felt, however, that we could play a significant role in easing two situations that the Indians particularly resented—lack of awareness on the part of the schools regarding the needs of Indian students and a general lack of communication between Indians and other residents of the community.

Overcoming resistance

Initially, we had difficulty convincing the Indians that we really wanted to help them. Our committee offered its services to the Intertribal Council, an OEO-funded organization designed to help the Indians on reservations improve their living conditions, but nothing came of this. When the Intertribal Council sponsored a meeting on housing problems, however, one of the social workers assigned to the Viejas Reservation obtained an invitation for several members of our committee to attend. Specifically, we were asked to furnish a speaker to describe the provision in California's public welfare program for funds for special housing needs. We shared the platform with representatives from the Intertribal Council of California, the Indian community action program, the Bureau of Indian Affairs, and the Department of Housing and Urban Development.

The committee members who attended this meeting

observed the Indians' ambivalence toward "outsiders." On one hand, the Indians appeared to want help; on the other, they tended to reject proffered assistance because they did not trust non-Indians. More than once during the discussion, Indian leader angrily spoke of white men who had offered to assist them but who never had returned with the help. They also pointed out that some white "helpers" had had ulterior motives—motives that resulted in exploitation of the Indians.

The meeting, although marked by "friendly suspicion," proved the starting point for our committee's subsequent work. That night the Indians asked one of our members to write an article for the newsletter of a statewide Indian organization about how persons receiving public assistance could obtain funds for housing repair.

Knowing that these Indians' experiences with white men have been characterized by broken promises, our committee members resolved that we would follow through on every project we initiated.

At one point during the meeting, the Indians discussed the U.S. Department of Agriculture's commodity distribution program, a Federal plan that makes staple foods available to low-income families. In San Diego County, the welfare department administers this program and volunteer agencies distribute the commodities from centers to which the recipients must come. One speaker said that Indians who qualify for the program had to travel from 15 to 60 miles to reach a distribution center. Claren Brown, the spokesman from the Viejas Reservation, described the difficulties that the older Indians had in obtaining commodities. With no public transportation available, many had no way to get to a distribution center. Others, after traveling long distances, sometimes found the distribution center unable to provide commodities. To remedy this situation, the Intertribal Council planned to set up its own commodity distribution center.

Later we learned that the Indians' distribution center would be located 60 miles away and would not be able to serve the Viejas and other Indian tribes in our part of the county. We then found a distribution center 30 miles from the Viejas Reservation that agreed to cooperate with us. The tribal spokesman and the tribal council helped us set up a commodity delivery service for 18 families on the reservation. Volunteers from the committee spent one evening each month working on this project.

From the first we realized that the Indians would not permit us to help them in meaningful ways unless

Edmund Dimock and Barbara Riegel were supervisors of aid to families with dependent children and child welfare, respectively, in the El Cajon office of the San Diego County Department of Public Welfare at the time they initiated the project described here. Miss Riegel is now assistant district chief in charge of services in the Escondido office; Mr. Dimock attends the graduate school of social work at San Diego State College.



gained their trust. The commodity project offered concrete evidence of our desire to help. However, because we did not involve the Indians in the actual pickup and delivery of food, we were not as successful with this project as we had originally hoped. Also, because of heavy demands on our time in providing services to the Viejas Reservation, we were unable to develop food distribution projects on any of the other reservations in need of similar services. However, we helped representatives from two smaller reservations arrange to get commodities from a nearby distribution center that had not previously been open to their people.

As an outgrowth of our demonstration of the need for a countywide food delivery service, last fall the Intertribal Council obtained a truck, and hired a food commodity coordinator and a driver. These positions are both staffed by Indians. When the Indian delivery service began in September 1970, we discontinued that part of our activities because there was no longer a need for our volunteers to deliver food.

Interesting others

During our activities on behalf of the Indians, we found that as a segment of the county population they were an almost invisible minority; the average white citizen of our county was unaware of the number, location, and population of the reservations. This was true even in the small city where the Viejas Reservation Indians shopped. Moreover, the white residents who did know about the Indians were not particularly concerned. Their idea of help was to donate their discards—broken toys, wornout appliances, and clothing with buttons and zippers removed. Both the adults and children who received the items were disgusted; one Indian parent said, "I don't know *anyone* I would give old things like that."

To date we have been unable to change this pattern of giving, undoubtedly because the givers have a stereotyped image of the Indian and a general lack of information about his needs. Those of us who work with Indians know that their needs are no different from the needs of other minorities—better education, jobs, and housing. Most of all they need to be recognized as individuals who have a contribution to make to society.

In the eastern part of the county, a group of merchants, public officials, and school administrators was working to modify the community's white, middle-

class attitudes toward minorities. Although blacks and chicanos were represented in this group, there were no Indians. Our committee sent a speaker to describe our commodity distribution project to this group, which showed a great deal of interest in local Indians and their problems.

After the meeting a local newspaperman interviewed several of us about our committee's work. We convinced him that the Indians' plight was much more newsworthy than our committee's small efforts, and arranged for him to meet Mr. Brown, the spokesman for the reservation. Since that time the daily newspaper has published several articles and editorials about the Indians' problems.

The community group promptly took up the Indian cause with fervor. Devoting many meetings to the subject, the group heard speakers from the Public Health Service and the Bureau of Indian Affairs discuss the water problem, which was different for each reservation. Its members arranged tours of local reservations, led by tribal leaders and Bureau of Indian Affairs staff. Next the group held an open house at a local high school to enable interested white citizens to meet and talk with Indians about their needs, including an adequate water supply. As a result, its members solicited funds and materials from businesses to improve conditions on the reservations. They obtained pipes through the Sears Foundation to use in replacing the waterline to the Viejas Reservation. The work is now being done by Mr. Brown and some volunteers. The community group also sponsored a Human Rights Day that honored racial and ethnic minorities residing within the community.

Tutoring

Our committee has also been involved in tutoring schoolage Viejas children. We proposed this tutoring project during a meeting of the Viejas tribal council. The council members cordially received our offer and told us that they were willing to provide the clubhouse and utilities at their expense. Mr. Brown, the tribal spokesman, assumed overall charge of the project, as he does for all reservation matters.

Neither the elementary nor the high school offered a balanced presentation of Indian history in its curriculum. Textbooks contained only the cowboy-and-Indian type of reference. Moreover, Indian parents had keen memories of the slights they experienced over the years at the hands of teachers, administrators, and school nurses. For example, although the Indian children were meticulously groomed, the



Viejas Indian children in San Diego County, Calif., get help from a volunteer tutor who visits the reservation weekly.

nurses frequently asked the children about personal hygiene and bathing. Ironically, the California Indians have had a long tradition of daily bathing, in the belief that it makes them stronger and healthier. Teachers described Indian children as withdrawn in the classroom and prone to fighting on the playground. The fights frequently stemmed from the racial slurs that the children experienced—such as “dirty black Indian” or “nigger.”

Because of our own observations of the high dropout rate of Indians in the ninth or 10th grades, members of our committee considered the tutoring project vital for helping these Indians achieve expertise in asserting their rights. The views of the parents coincided with ours, and most of them have received this project with enthusiasm. The tribal spokesman delegated to his sister, Florence Barrett, secretary of the council, the task of assisting us in establishing the tutoring project. She contacted parents, gave us information on each child on the reservation, and made arrangements for all the preliminary meetings and tutoring sessions at the clubhouse. A consultant on Indian languages to the linguistics department of the University of California at San Diego, Mrs. Barrett has a keen interest in seeing her own four children complete college. It is doubtful the project could have been sustained without her dedication and help.

Some tutors volunteered after reading newspaper stories about the project; others were recruited by friends. The tutoring group eventually included 35

people, including 12 public welfare workers, a number of college students, and several housewives. Each volunteer tutor donated a minimum of 3 hours a week. Generally, the initial group has remained active, except for two social workers who returned to graduate school. Although most of the tutors worked or lived within 20 miles of the Viejas Reservation, few of them had had any knowledge of Indian problems before joining the project.

The tutoring “school” began operation in June 1969. It now has 35 elementary school children attending. We have emphasized reading and mathematics, although we have helped students in all the school subjects. Because of the limited time available, one tutor could devote to this project, we planned only one 2-hour tutoring session a week for each child. A measure of the school’s success is the large number of children who drop in without appointments to obtain help with homework. Some evenings when we are swamped with drop-ins, we utilize older students to help younger ones.

From the beginning the tutors noticed an overwhelming, almost immobilizing, lack of self-confidence in the younger children. By the time they had passed the sixth grade, the children had developed a hostility toward school and an attitude of not caring about their progress. This might be called the predropout syndrome.

In addition to academic help, we arranged special activities for the Indian children, such as picnic trips to the zoo and beach, a tour of the college that several tutors attend, a Halloween party, and a Games Day on Labor Day.

Public school teachers told us that most of the children who were tutored showed improvement during the last school year. These children seem to be most interested in music and art, while arithmetic and reading remain rather tedious subjects for them. In several of the readers that the schools donated to us, we found prejudicial stories perpetuating the image of the primitive Indian. Eventually we discontinued using such books.

We were unable to reach the Indian high school students on a sustained basis. Of the six we knew, two were good students and did not need us, while four who needed a considerable amount of help were too embarrassed to admit it. They remained interested bystanders and enjoyed the social contacts with several tutors. By the end of the year, three of the marginal students had dropped out of school.

Stimulated by the interest of Indian parents in educational courses for themselves, the adult di-

on of the high school initiated an adult school at a convenient location on the Viejas Reservation in April 1970. Establishment of this school was a most gratifying result of our contacts with the tribe. High school level courses were taught from April through June. The first class included seven adults and five recent high school dropouts, three of whom we had persuaded to enroll. Funds have not been available to continue classes in 1970-71.

Changing attitudes

Although our tutoring project brought no direct improvement in the teenagers' school performance, we made some progress in changing attitudes of teachers and administrators toward the Indians. Committee members held numerous meetings with the school guidance staff to try to establish communication between them and the parents and to foster a more understanding approach on the part of the school toward the students. The high school responded by requesting funds to employ an Indian teacher-counselor to develop more relevant materials and methods for the Indian student. This special project began in September 1970, under the direction of a Sioux Indian as teacher-counselor. A former volunteer in our tutoring project, she is admired by the Indian residents for her talents and her pride in her cultural background.

A junior college scholarship program for students of minority groups, including Indians, is scheduled to get underway in September 1971. When funded and implemented, the program will offer courses on the reservation to anyone over 18 years of age. Indians will participate in formulating the courses of study.

After several meetings at the reservation clubhouse, communication between the Indian parents and the school improved. The parents, who had previously withdrawn from contact with school personnel, were surprisingly outspoken in their criticisms of past and present injustices occurring in the school. Expressing their belief that the white schools did not

want their children, the parents cited many incidents arising from misunderstandings as proof of this. They told of insulting remarks made by white students or teachers, which they viewed as part of a general pattern to discredit Indian children. Furthermore, they said that whenever fights erupted at school, Indian children were automatically blamed as the instigators. They charged that their children were treated as slow learners. As children these parents had attended the Alpine grammar school during the 1930's and 1940's when there were separate restrooms for "Indians and colored." Many problems remain in relation to the public schools, but the initial steps toward greater understanding are taking place.

Although the people on the reservation have no outstanding artifacts or commercial products, they have preserved certain elements of their culture. Most of the middle-aged and all of the elderly Indians know the Diegueno language, but they have made no formalized attempt to teach it to the children. After listening to some members of the tribe express concern that their culture and language are dying, we decided to initiate a course on their culture for the children with the aid of parents and a local anthropology professor. So far, however, we have not had an opportunity to work on this project.

At the beginning of our volunteer work on the Viejas Reservation, we were bombarded with attitudes of hopelessness, even on the part of very young children. "It won't work" was the standard response to our efforts. We now hear parents say indignantly that the school owes their children a decent education. In spite of a tradition of never expressing anger, these Indians have begun to do so. It seems to us that they are aware of changes in the white society's attitudes toward minorities that will inevitably lead to improvement in all areas of their lives.

One byproduct of our committee's project is the education we have received from our association with the Indians. We have had the rare opportunity of learning directly from the Viejas Indians themselves about their values and life styles. These encounters have been uniquely enriching experiences for us.

RECENT DEVELOPMENTS IN KOREAN SERVICES FOR CHILDREN

HELEN MILLER

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● Twenty years ago the Communist forces crossed the 38th parallel into South Korea, and the country became for 3 years an international battleground. As always in a country that is being fought over, children were among the major victims. The children who were maimed or orphaned in that war have now grown up, but the country's social services to children still reflect some of its aftermath—in the dominance of institutional programs and in the dependence in large part on foreign support and technical aid.

The plight of the orphaned children after the Korean war caught at the heartstrings of Americans, and financial aid poured into the Republic of Korea in abundance. Only in the past year have funds from overseas begun to decline.

In 1953 the country's economic and social structure was practically in shreds. At first mass care was the only means of insuring survival for orphaned children and widows with small children.¹ The number of orphanages increased from 38 in all Korea in 1945 to a peak of 602 in South Korea in 1967.² The terms "social service" and "institutional care" became almost synonymous.

While the Republic of Korea is committed to establishing a broader network of social services and economic assistance, the current 5-year plan is focused almost entirely on economic development and defense. In fact, only 2 percent of the national budget is allocated to health and social services. The public family economic assistance program, which provides the equivalent of \$3 per month per recipient, aids only

2,000 children. At the same time 62,000 children live in 557 institutions financed largely through contributions from western countries.²

Institutional care

Why are there so many "orphanages" and why have they continued to function so long after the end of the war?

There are many reasons. For one, there has been a continuing inflow of a new kind of "orphan"—the abandoned child. These children have been left in bus stations, in clinic waiting rooms, and on the doorsteps of institutions. The number of abandoned children rose from 715 in 1955 to a peak of 11,319 in 1964. In 1969 it was down to half that number—5,663.

Nearly all the children's institutions are privately owned. In many cases the superintendent-owners are loathe to close down because this would mean not only losing their incomes, but also depriving their own children of future employment. Moreover, Government regulations make it difficult for an owner to recoup the sizable investment required for incorporation.

Some superintendents have set up institutions near American military installations because servicemen give direct service, such as medical care. Many U.S. Army units support such institutions.

In addition, there is another kind of "orphanage child"—one who lives in an institution while remaining in contact with his family. The names of such children pad the roles of the "orphanage" to support requests for contributions from overseas. The Korean Government reports that over half the

children in institutions have families.

Efforts to evaluate the institution services and develop alternative methods of helping children have been hampered by the frequent turnover of personnel and the lack of qualified social workers in the child welfare programs of the Korean Government and foreign agencies. However, some efforts have been made to improve institutional services. In 1957, for example, the Korean Government set up a National Social Workers Training Institute to give short-term training to child care workers, orphanage superintendents, and government employees. Built with U.S. funds, this institute operates with technical aid and economic support from the United Nations Development Corporation and UNICEF.

The Mennonite Central Committee training program for child care workers, begun in 1963, has been outstanding. The Swedish Save-the-Child Federation recently established a similar training program for day-nurse teachers. World Vision Hospitals have provided excellent medical services to orphanages at minimal cost. Nevertheless, care of children in Korean orphanages too often remains merely custodial.

Child abandonment

Why are so many Korean children abandoned? Poverty, once a major reason, has become less important as the nation's economy has become stabilized. Many children, born in and out of marriage, are unwanted. About one-fourth of the abandoned children are infants under 1 year of age. In this group outnumber boys as much as three to two, reflecting the Koreans' traditional attitude toward females. However, almost 35 percent of the abandoned children are over 6 years of age, and two-thirds of this group are boys because girls can earn money as domestic help.

Lack of social and health services in families have been large factors in child abandonment. Tuberculosis, a disease that affects 5 percent of Korea's population, and other chronic illnesses have caused the breakup of many impoverished families.

Another reason for abandonment apparently is the parents' desire for education and economic betterment for their child. If they can benefit the child by giving him away, they will do so. In fact, children of poor families have

ditionally been given to richer, wealthier relatives to adopt or raise. Children in Korean orphanages have generally received more education than children in the average low-income family. A 1965 study of 188 adults who had been raised in institutions found that 79 percent were junior high school graduates and 10 percent college graduates.⁴

While school attendance is compulsory in Korea through the sixth grade, it is not free: when parents cannot pay the school fees, their child is forced to leave. It is not accidental, therefore, that many boys are abandoned when they reach school age.

Services to families

Some foreign social agencies provide help to families, but these programs are all in comparison to the great aid of the Save-the-Children Federation (SA), which emphasizes rural development, provides that a portion of the money contributed by sponsors goes to the child and his family and a portion to the village for economic development. In 1962 the Christian Children's Fund instituted its family helper service to provide cash for a child living in his own home. Previously the CCF only aided children living in institutions. Last year one-third of all children on CCF roles were helped to live at home with relatives.

In 1965, Korea Church World Service upgraded its family relief program in Seoul to a family welfare service, under the direction of an American social worker. This program, now closed, had a twofold emphasis: demonstrating the use of professional social service to families and providing inservice training for staff members and students. Catholic Family Social Services have been set up in a few cities.

The Korea Lutheran Mission has incorporated a small family welfare program into the local church structure. As part of the Diakonia program, it is designed to instill a social conscience in members of the congregation and create channels for them to help others in the community.

Unfortunately, the excellent cooperative and family-service effort in one of the Han River slum areas in Seoul⁵ ended in 1969 for lack of funds. The project was supported for 4 years by several voluntary agencies as a demon-

stration of a program that the city should adopt, but the city failed to accept full financial responsibility. Nevertheless the program more than proved its worth: not a single child was abandoned from the area in its 4-year existence.

In 1965 several foreign agencies combined with the Child Placement Service, a semigovernment child care agency, to help children of mixed race accept themselves by providing counseling, economic help, education, and community involvement. Known as ECLAIR (Eurasian Children Living As Indigenous Residents), this low-keyed program has produced such results that Child Placement Service is now able to carry on the program alone.

In January 1966 an abandoned children's center was set up in Mokpo City by the Unitarian Service Committee of Canada. While abandoned babies are cared for, efforts are made to find the parents. If they are found, the parents receive counseling and material and medical assistance as needed to help them keep the child at home. About 17 percent of the children accepted for care in the center have been returned home. This program has received broad community support.

Changing emphases

The child welfare law of 1962 created the position of child welfare worker in each county, but the poor salary, low job status, and "boondocks" location of most of the jobs cause constant turnover. Many of the child welfare workers have only a high school education.

In the early sixties the Government sought to place orphanage children in foster families; quotas were set and Government employees were expected to take children into their own families. This program was unsuccessful.

Adoption agencies, beginning with International Social Service in 1964, have had greater success in finding Korean boarding homes for babies.

Early in the sixties the Korean Government, with technical and financial assistance from the United States, Sweden, and the World Health Organization, instituted a family planning program. Subsequently the birth rate has dropped from 30 per thousand in 1960 to the present 23 per thousand. While the third 5-year plan calls for the birth rate to be reduced to 1.5 per-

cent by 1976, further reductions will be hard to achieve because of the value Koreans set on children, especially sons.

Day nurseries are increasing in Korea, and about 200 nurseries are enrolled in the Day Care Nurseries Association created in 1969 to upgrade child care. Institutions are being encouraged by the Ministry of Health and Social Affairs to shift their programs to day care. Social welfare agencies have cooperated. Both private industries and the Government have established centers for infants of employed nursing mothers. In many cities day nurseries for kindergarten-age children have become businesses, and it is a sign of prestige among the newly rich to enroll their children.

The idea of day care is taking root in some villages, under the auspices of the Government's rural community development programs and voluntary social agencies. Usually local churches give their support.

Another encouraging sign is the program launched last year by the Women and Children's Bureau, Ministry of Health and Social Affairs, to carry responsibility for the welfare of all children. Previously the agency had been concerned only with institutional and vagrant children.

Last year the Labor Office also established a Section on Women and Children, to be responsible for protecting rights and preventing exploitation.

Adoptions

International adoptions of Korean-American children began in 1953 when the Seventh Day Adventist Church placed a few children with American families. These were soon followed by Harry Holt's efforts on behalf of "mixed-race" children. Although there

Reflecting the changing attitude toward adoption in Korea, these young parents complete arrangements for adoption.



are not many children of mixed race in Korea, such children meet with considerable prejudice because of Korean pride in "pure" family lines.⁵ Most of them are the children of American soldiers.

The Holt adoption program places more Korean children than all other agencies combined. In 1969 the program placed 704 children with American couples. It now helps full-Korean children who are hard to place because of age or physical problems as well as mixed-race children.

In recent years two Korean adoption agencies have been formed. Almost from the start, they have placed full-Korean as well as mixed-race children in Canada and Europe and with American military families overseas.

The recently introduced western concept of society's responsibility for the welfare of all children is still alien to many Koreans, who follow the Confucian teaching that the responsibility for persons who are blood kin rests with the family.

Thus a behavior pattern almost as strong as a taboo is being reversed as Korean families are beginning to adopt children to whom they are not related. Probably more than 1,000 children were adopted in Korea last year. Most placements for adoption are made by superintendents of children's institutions or child welfare workers, who are so inexperienced in this new service that they have allowed families to "try out" several children. There is some reason to fear that girls are sometimes adopted to be used as maids.

To combat these dangerous practices, Christian Reformed Korean Mission is pioneering an adoption program to demonstrate quality service, set professional standards, and instill a broadened understanding of adoption. In less than 3 years the agency's placements of children in Korean families have tripled.

An abandoned Korean infant is examined upon arrival at a social service agency.



although its eligibility requirements have become more stringent.

Needs of youth

A growing recognition of teenagers' needs for recreation has resulted in a request by the Ministry of Health and Social Affairs for funds to build and repair playgrounds and youth halls. More important, the Ministry is encouraging use of local churches, schools, and public buildings for recreation.

In rural areas, the 4-H program is a potent force in giving young people pride in their own activities. Begun just before the Korean war, the 4-H Clubs in Korea have reached an enrollment now second only to that of U.S.A.

For a decade or more churches have run evening academic courses as well as Bible studies for young people who work during the day. Police departments have set up programs of residential care for street boys, and have encouraged them to shine shoes or sell newspapers; YWCA programs have included training in sewing, knitting, and embroidery for home industry.

Several Catholic orders have established residential vocational training schools for underprivileged young people, notably the Salesian Fathers' 3-year school for auto mechanics and the Good Shepherd Sisters' courses in typing. These are a refreshing change from the usual hairdressing and barbering courses.

Vagrancy among children is decreasing. After reaching a high of almost 30,000 in 1964, the number of vagrant children dropped to slightly over 20,000 in 1969. On the other hand, runaways have increased nearly 300 percent in 6 years—from 7,011 in 1962 to 20,663 in 1968. In a recent study of 200 teenagers who ran away for the first time, 50 percent said the major cause was "unhappiness with family."⁶ Only 10 percent gave poverty as a major reason.

These 200 teenagers were lucky because they had been brought by the police to official reception centers. All too often youngsters arriving in a city without plans or resources get into real trouble; girls are shuttled into prostitution, and boys join gangs that live by theft. To prevent such social casualties, church workers in some cities meet trains and buses to spot newcomers and help them make realistic plans. Many such youngsters and their parents are

desperately in need of counseling.

When they do secure employment these young people have great difficulty finding housing. Although dormitory facilities are operated by the YMC YWCA, and the Government, they have long been inadequate, and only a few other social agencies provide housing. One solution would be for orphanages to be transformed into hostels or cooperative housing, but this idea has not caught on. Some enlightened factories provide dormitories for new employees.

Rapid urbanization, breakdown of close family ties and traditional values, and the imbalance of incomes have resulted in a growing problem of juvenile delinquency in urban areas. City police departments have set up special juvenile delinquency sections, but few are staffed by persons trained to deal with youth.

Girls' Welfare Association, a rehabilitation service for former prostitutes, was begun 12 years ago under auspices of a religious mission. It has become an effective catalyst in changing attitudes on how to deal with prostitutes. A comprehensive program has been successful that Kyonggi-gi Province and Seoul City have asked the agency to upgrade the Government vocational guidance centers for such girls.

Thus, social services in Korea are gradually moving from institutional care to preventive help. Originally funded almost entirely from overseas, these services are slowly being supported by Koreans and assimilated into the Korean culture. As Korea achieves an independent economy, the Government will be free to turn its attention to the social welfare needs of its citizens.

¹ Tieszen, Helen: Changes in service children in Korea. *Children*, January-February 1966.

² Republic of Korea, Ministry of Health and Social Affairs: Year book of social statistics 1969. Seoul, Korea. (All quoted Government statistics are taken from this source.)

³ Alvernaz, Rose; Tieszen, Helen: Technical assistance for child welfare in Korea. *Children*, July-August 1958.

⁴ Proceedings of the Ninth Annual K. Conference, 1965. Seoul, Korea.

⁵ Chakerian, Charles G.: From rescue to welfare. Church World Service, New York, N.Y. 1968.

⁶ Chang, In-Hyub: A study of runaway youngsters. 1969. Unpublished manuscript. Seoul, Korea.

ADVOCACY FOR CHILDREN: CHALLENGE FOR THE 1970's

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When "Action for Mental Health"¹ was published a decade ago, there was widespread concern among people involved with services to children that the child part of the population had been shortchanged. Children seemed to have been completely omitted in the very exciting proposals for the reorganization of mental health care in the United States. As a result of this concern, the Joint Commission on Mental Health of Children was established in 1965, and its report was offered to the Congress in June of 1970. This report is now available to the public in the recently published book, *Crisis in Child Mental Health*.*

The book represents a broad and comprehensive study of child life in America. It points to a host of ways of improving the care of children, many of which seem impractical. Yet it may stand as an important landmark for the next pair of decades in organizing services for children. But if it is to have real impact on children's services, as well as in their lives, it will have to be read and re-read. It will have to be applied both for what its recommendations urge and for what they omit.

The professional persons from many disciplines, who wrote the basic material

from which the report was derived and who collaborated in arriving at its recommendations, are to be greatly commended for pulling together a vast amount of knowledge about children in this country. The opening chapters discuss the society in which we and our children live in relation to its effect on the mental health of children in general; on family life; on children who live in poverty and on children of minority groups. The last chapter in this group, entitled "Emotionally Disturbed and Mentally Ill Children and Youth," presents a picture of the clinical situation as it exists today. Other chapters discuss the social-psychological aspects of normal growth and development in infants, young children, and adolescents, and education, employment, and research needs.

The success of the collaborators from a variety of fields in accumulating and presenting this wide spectrum of knowledge about children demonstrates the importance of collaboration and the joint presentation of material. Diversity of viewpoints shines through and affects many of the recommendations. Nevertheless, the book not only suggests that professional persons have a major role in understanding, alleviating, and modifying the progress of child development, but also emphasizes that they must unite in a political effort to see to it that the proposals outlined in the text are carried out.

The book presents a series of recommendations, based chiefly on its findings on the effects of American society on

children. These recommendations urge all levels of government to expand services for children and to coordinate them. They renew the ever-constant plea for more community services and programs of a supportive, preventive, and remedial nature, and for more research pertinent to child development and ways of serving children. In addition they tackle the major problem of manpower and training with the most innovative and possibly the most important recommendation of all: the establishment of a system of advocacy for children.

This advocacy system is recommended to support existing services and a proposed grid of community services that would stem from the highest office in the land down into State, local, and community facilities. The recommendation derives directly from the premise of the Commission, stated clearly in the opening sentence of the book, "We proclaim that we are a nation devoted to its young." This intriguing sentence suggests that although we have made tremendous strides in thinking about children, our thinking has been only partly used in practical ways, at times misused, and too often abused.

Some omissions

The various technical chapters point out that the defects in our system of caring for children in this "century of the child" stem from many conflicting cultural factors. Some of these are spelled out; others are omitted.

CRISIS IN CHILD MENTAL HEALTH: CHALLENGE FOR THE 1970's. Joint Commission on Mental Health of Children. Harper & Row, Publishers, New York, N.Y. 10016. Pp. 578. \$10.

In its description of the situation of minority groups the book clearly points out that while the benefits of middle-class culture nurture the development of children, the deprivations and the antagonisms experienced by minority cultures tend to hinder development. While some of the basic cultural taboos, biases, prejudices, and overt obstacles to progress are listed, the influence of strong societal forces in keeping minority groups down is not as well documented. The fact that there are political and social forces in our society that say to the poor, "you are poor and you should stay so" is not made as clear as is the impact of this type of thinking on the development of children. Thus the chapter on racism, which so neatly spells out the hazards to children of ancient biases, neglects much of the thinking that lies behind this noxious factor in our society.

Everyone concerned about children will be pleased that the report strongly emphasizes the importance of interest in problems of the very young child and his family. However, it does not present a clear blueprint of what changes need to be made to meet the needs of early childhood. There is no direct reference to the political forces that openly weep about the plight of resources organized to care for children and at the same time operate in a way that reinforces segregation, deprives the poor and the minorities of political power, and makes sure that the legal as well as the educational needs of many parts of the population are not satisfactorily met.

Thinking about children

In spite of these shortcomings, creative, idealistic, and innovative recommendations form the core of this report. Perhaps the most important message is that our thinking about children would be improved if we actually *thought* about children.

This is the concept that underlies the Commission's proposal for an advocacy system. Many professional persons have dreamed of an advocacy system of some kind that would focus the national ef-

fort on the needs and the worth of the child population. As proposed by the Commission, the advocacy system would be spearheaded in the Office of the President where an advisory group, invested with power, would assist the President in looking at the problems and needs of children. Such a group would extend its power, as well as its advice, downward to the health, social, and educational services throughout the country. Similar advocacy groups set up at State and local levels would be organized to look at the defects and gaps between services, resulting both from bureaucratic structure and from human frailty.

Such a network of advocates for children would make it possible to look at those things that impede the development of services for children as well as those that oppose the general health and welfare of minority groups. Not the least of the impediments to better service is the sense of competitiveness in our present system of services that prevents one service from appreciating the value of another. This type of myopia has often stood in the way of providing the broad range of help that is needed for children.

As I have already noted, professional persons of many types came together to write this document. They are to be congratulated for reemphasizing the gaps and the difficulties that exist in current structures of children's services and for demanding that the thinking about these services embraces ideas not only of professional persons from a variety of disciplines but also of lay citizens who must assume responsibility for supporting and enhancing the work of the professionals.

The main focus of the book is properly on prevention. Because of this, only one chapter deals with the clinical needs of emotionally disturbed and mentally damaged children. Still the needs of already damaged children must be taken into account in any consideration of the book's theme, "Crisis in Child Mental Health." One must remember, although the point is not noted clearly in the text, that the emotionally dis-

turbed children of today will soon become the parents of tomorrow and spread their problems in a kind of generational chain reaction.

The tasks ahead

The advocate plan may be fraught with political danger, but it provides a challenge that cannot be avoided. It must be tackled head on along with political and professional problems providing preventive, educational, and remedial services. The task of the professionals will be to investigate some of the quarrels between preventive and remedial services that are evident in the text of this book.

The proposed system of advocacy for children presents some hope that services will no longer be built on the conscious philosophy that children are second-class citizens. However, for such a proposal to have to be made in our country is in a sense an admission of failure—failure to live up to all that this country stands for. Obviously, the book points out, everyone should be an advocate for children. The fact is that a large proportion of the population seems indifferent to the unmet needs of children. Why is this so? Unless we can understand the fact that children are often a threat to us as adults, we will be left exactly where we were when the reports on which this book was based were written.

Young people throughout the Nation today are demanding "relevancy." To achieve such relevancy the reader of this book need not only to attend to its findings and recommendations, but also to attain an understanding of the difficulties intrinsic in the recommendations. With this book as a pilot, use its recommendations as guidelines, and continue a continuing search for practicality, ways of overcoming obstacles, and constant attention to relevancy, we can fulfill the purpose behind the writing of this document.

¹ Joint Commission on Mental Illness and Health: Action for mental health: final report. Basic Books, New York, N.Y. 1961.

BOOK NOTES

MORAL JUDGEMENT FROM CHILDHOOD TO ADOLESCENCE. 316 pp. \$7.50. MORAL EDUCATION. 185 pp. \$4. Norman J. Bull. Sage Publications, Inc., Beverly Hills, Calif. 1970.

In the first book the author reports the development of moral judgment in 360 boys and girls between 7 and 17 years of age as determined in a study completed in 1966. He found "striking" differences between boys and girls in most all areas of moral judgment: boys are tempted with lying, deceit, kindness, selfishness; boys with stealing, cruelty to animals, damage to property, self-indulgence.

"If concern for others is the heart of morality, the female is inherently more truly moral than the male," the author concludes.

The study was based on a battery of written and verbal tests that the author devised to trace the development of moral judgment in terms of a four-stage scale. The author defines the four stages as: anomie (anomie), or absence of conscience—premorality stage; heteronomy, or being imposed by others—external moral-stage; sociomorality, or social relations of reciprocity—external-internal morality stage; and autonomy, or self-imposed—internal morality stage.

In his study he also investigated the relation between moral judgments and the key variables—chronological age, sex, intelligence, socioeconomic class, and religious background.

The study found no significant association of any of the variables with the development of conscience, although it did reveal an association between low socioeconomic class and cheating and lying, especially for boys. While the study identified intelligence as a concomitant factor in facilitating development in moral judgment, especially for girls, it found that intelligence, of itself, does not guarantee high levels of moral thought and action.

In the second book, "Moral Educa-

tion," the author analyzes his research in relation to its implications for the moral education of young children, those in the middle years, and adolescents.

The author is head of the department of religious education at St. Luke's College, Exeter, England.

BLACK GHETTO FAMILY IN THERAPY: a laboratory experience. Clifford J. Sager, M.D., Thomas L. Brayboy, M.D., and Barbara R. Waxenberg. Grove Press, Inc., New York. N.Y. 1970. 245 pp. \$6.50.

This book is based on a role-playing demonstration in which four family therapists conducted separate interviews with the same simulated black intercity family during the 1969 conference of the American Group Psychotherapy Association in New York City. The "family" was composed of five mental health workers from the New York Medical College-Metropolitan Hospital Community Mental Health Center, who took roles of an unemployed father, depressed mother, pregnant unwed daughter, son who was a high school dropout, and church-going grandmother.

In addition to verbatim transcripts of the sessions between each therapist and members of the "family," the book presents comments from the audience discussion that followed the demonstration, retrospective comments by the therapists on their treatment styles and the theoretical framework in which they conducted their sessions, and comments by the mental health workers who portrayed members of the family.

The book discusses the problems of a white therapist in engaging a black ghetto family in treatment within the context of today's racial situation, as well as the problems of a black middle-class therapist in gaining acceptance by a black innercity family. It also examines problems in treating families whose primary concerns are subsistence and survival, the need for understanding in

the treatment of such families, and the need for models of psychopathology that recognize the patient's family situation and his cultural milieu as determinants of disturbed behavior.

Complex problems that face family therapists are cited, including absence of the father; truancy, delinquency, or drug use in youngsters; and abdication of parental control. Underscoring the need for a reappraisal of current therapeutic programs for the poor, the authors suggest that therapists "move into the community and earn a place in it."

THE HIGH SCHOOL REVOLUTIONARIES. Marc Liharle and Tom Seligson, editors. Random House, Inc. New York, N.Y. 1970. 275 pp. \$6.95.

This book is a collection of statements on reasons for student unrest made by 21 high school activists, selected from many more tape recorded interviews with the editors. When the project began in 1969, both editors were 24-year-old teachers in the New York City school system. They report that the statements selected for inclusion were chosen to give representation to various geographical regions; urban and rural areas; poor innercity, middle-class, and affluent neighborhoods; and public and private schools.

For the most part the students describe the conditions in their schools as "intolerable," their teachers as unqualified for teaching either intellectually or as human beings, and the school administrators as strictly authoritarian. They also expressed various degrees of disillusionment with the wider society.

DELINQUENCY BEHAVIOR IN AN AMERICAN CITY. Martin Gold. Brooks/Cole Publishing Company. Belmont, Calif. 1970. 150 pp. \$3.50.

Defining delinquent behavior as "offensive behavior of juveniles whether or not it is ever detected by authorities or anyone else," the author of this book says that there are "almost no non-delinquent adolescents." Most delinquent behavior is spontaneous performance, or action for approval, he suggests, and thus is a function of role inadequacy: when adolescents find themselves unable to live up to expectations in school, at home, and among their friends, they are driven to gain respectability in other ways.

Reporting on a study of teenagers in Flint, Mich., the author points out that interviews with 522 boys and girls between the ages of 13 and 17 revealed 2,490 admitted acts of delinquent behavior, all illegal, although some were relatively minor offenses. Only 3 percent of the group interviewed, or 47 young people, had police records.

According to the author, delinquent behavior seems most often to be a group activity for teenagers: in three-fourths of the admitted violations, two or more young people were involved. Nevertheless, the stereotype of an organized gang regularly and frequently committing delinquent acts together seldom fitted the Flint teenagers.

Parents were aware of at least one-

fourth of their children's delinquent acts, the author reports, but they seemed unable to do anything about them. He also found that poor performance in school seemed to lead to delinquent behavior among boys, but not among girls.

A CHILD'S MIND: how children learn during the critical years from birth to age five. Muriel Beadle. Doubleday & Company, Inc., New York, N.Y. 1970. 294 pp. \$6.95.

Addressed to "intelligent laymen," this book describes recent studies by psychologists and psychiatrists relating to the mental development of children and the course that learning takes

during the earliest years of life. Children are never too young to learn, the author says, citing research to show that about 50 percent of the development of general intelligence takes place between conception and age 4.

In pointing out that children are highly individual, the author lists the variables that influence their development: biological inheritance; physical and social environment; and timing or the point at which environment and heredity interact. Among other topics the author discusses the biological basis of behavior, development of concept information processing in young children, measurement and inheritance of intelligence, and how environment affects intelligence.

GUIDES and REPORTS

TOYS AND GAMES FOR EDUCATIONALLY HANDICAPPED CHILDREN. Charlotte A. Buist and Jerome L. Shulman. Charles C Thomas, Publisher, 301-327 East Lawrence Avenue, Springfield, Ill. 62703. 1969. 228 pp. \$9.50.

Suggests toys and games for developing accuracy of perception, retention and recall, conceptualization, and expression, classified according to age and sex interest and the intellectual skill required.

CHILD ABUSE LEGISLATION IN THE 1970's. Vincent De Francis. The American Humane Association, Children's Division, Post Office Box 1266, Denver, Colo., 80201. 1970. 134 pp. \$1.50.

Presents a study of current child abuse reporting laws in each of the States and territories, and discusses problem areas and novel approaches.

A PRACTICAL GUIDE ON HEARING IMPAIRED CHILDREN. Alfred L. Miller and Roger Lehman. Charles C Thomas, 301-327 East Lawrence Ave-

nue, Springfield, Ill. 62703. 1970. 69 pp. \$5.50.

Describes the anatomy of the ear, physiology of hearing, diseases, treatment of hearing loss, basic procedures for conducting hearing tests, and use of hearing aids by children.

THE CHANGING DIMENSIONS OF DAY CARE: highlights from *Child Welfare*. Child Welfare League of America, Inc., 44 East 23rd Street, New York, N.Y. 10010. 1970. 62 pp. \$1.75.

Contains 11 articles on aspects of day care—philosophy, policy, community planning, board members, administration, staffing, the role of social work, day care as a resource, and its values for children.

CHILDREN IN RESURRECTION CITY. Walter E. Afeld and Audrey B. Gibson. Association for Childhood Education International, 3615 Wisconsin Avenue, NW., Washington, D.C. 20016. 1970. 48 pp. \$1.50.

Describes the day care center for

157 children in Resurrection City, Washington, D.C., in the summer of 1968, and the problems of working with children in an atmosphere of confusion and considerable family organization.

IN LOCO PARENTIS: a study of perceived role values in foster home care. Harry Gottesfeld. Epilogue by Elizabeth K. Radinsky. Jewish Child Welfare Association of New York, 345 Madison Avenue, New York, N.Y. 10017. 1970. 40 pp. \$1.25.

Reports on a study of the values of 75 children placed in foster family care, and those of their foster families, their parents, and their foster workers, and the agency changes resulting from the study.

FINANCING HUMAN SERVICE PROGRAMS. Rocco D'Amico and She P. Todd. Institute for Interdisciplinary Studies, American Rehabilitation Foundation, 1800 Chicago Avenue, Minneapolis, Minn. 55403. 1970. 122 pp. \$5.

Presents guidelines and case illustrations to help States improve their programs of human services by making optimum use of the Federal grant aid available through the Department of Health, Education, and Welfare.

HERE and THERE



Lead poisoning

All children between 1 and 6 years of age who are living in old, poorly maintained houses, or are otherwise exposed to the hazard of lead poisoning should be included in screening programs to determine the levels of lead in the blood, according to guidelines for attacking lead poisoning issued last November by the U.S. Public Health Service. An "old" house is defined as one built before 1940 when the use of the lead-based paint for interiors was largely discontinued.

In brief the guidelines advise that—

Children with a concentration of 10 micrograms or more of lead per 100 milliliters of whole blood should be considered medical emergencies and be hospitalized immediately for treatment with lead-removing drugs (chelation therapy).

Children with blood lead levels of 7.5 to 9.9 micrograms of lead per 100 milliliters should be referred for diagnosis through laboratory tests, and followed closely with periodic determinations of blood lead levels if the tests are negative.

Children with blood lead levels of 10 to 14.9 micrograms should be recalled for an evaluation to determine their current exposure to a lead poisoning hazard and for periodic followup if exposure continues.

Children diagnosed as having lead poisoning should be treated immediately, removed from the source of lead exposure until corrective action has been taken, followed up carefully until 6 years of age or older to prevent further exposure, and assessed for any evidence of minimal brain damage or other sequelae of lead poisoning.

Sources of lead must be removed from the environment of children who

have absorbed hazardous amounts into their blood.

- Dwellings identified in the screening program as potential sources of lead hazards should be brought promptly to the attention of the local government agency responsible for enforcing regulations to bring about corrective action.

- Lead poisoning should be made a reportable disease.

Transracial adoptions

The pros and cons of placing black children with white families for adoption received a major portion of attention at the Second International Conference on Transracial Adoption, held in Boston, Mass., November 13-15, 1970. Among the 600 participants many were white parents who had adopted black children or children of mixed black and white origin.

In the keynote address, Ursula Gallagher, consultant on adoptions for the Children's Bureau, pointed out two conflicting trends: the growing acceptance of black children by white couples seeking to adopt and the active opposition among some blacks to the placement of black children with white families because of possible hazards to the children's ability to achieve inner security and a sense of identity. She pointed out that the practice of making black-white placements arose in recent years among adoption agencies because an excess of black children in need of adoption over black applicants for children made transracial adoption seem the only alternative to the children's having to spend their childhood without homes of their own. Granting that transracial adoptions may involve some special problems, she said that they demanded great strength on the part of the adoptive parents in understanding the needs

of children and in ability to deal with their own racial attitudes as well as the attitudes of others.

In 15 group sessions following the keynote address the participants discussed subjects of concern to agencies and parents involved in transracial adoptions. Some of these subjects in themselves suggested possible alternatives to transracial adoptions: greater efforts to recruit adoptive homes in the black communities; the acceptance of single persons as adoptive parents; the subsidizing of adoptions; and the use of national and statewide adoption resource exchanges.

In other group sessions, attention was focused on ways of making transracial adoptions work. A number of white parents present spoke enthusiastically about the satisfactions they received from their own experience in adopting a black child. Some were confident that their attitudes could change hostile community attitudes.

Many of the participants expressed the feeling that the child in a transracial adoption could work out his identity problem satisfactorily if he were offered a great deal of love and security in the home. There was recognition, however, that this might become difficult in a time of increasing racial awareness. The point was made that little is known about the kind of defenses that might be built up in a black child brought up in a white social environment. One black participant said he would only approve adoption of black children by white parents if the parents were ready to face the reality of white racism and black militancy and protect the child from the inner conflicts that these would arouse.

Among other subjects discussed were the motivation of transracial adoptive parents, the development of special adoptive agencies, legislative action and adoptive policy, alternatives to the social work manpower problem, and services to children who wait.

Children's TV

Educational TV programs can reduce the learning gap between advantaged and disadvantaged children, according to an evaluation of the effects of "Sesame Street," the popular program for 3- to 5-year-olds, reported last November. The evaluation was made for the Children's Television Workshop, pro-

ducer of the program, by the Educational Testing Service of Princeton, N.J. It involved the selection of samples of children, divided into watchers and nonwatchers of "Sesame Street," from four population groups—low-income inner-city, middle-class suburban, rural, and Spanish-speaking—and testing them at the beginning and end of the program's first year on items taught in the program.

The findings showed that—

- Disadvantaged viewers who were regular watchers of the program made higher test scores than middle-class children who did not watch the program.

- Three-year-old viewers gained the most from the program, making higher test scores than 4- and 5-year-old nonviewers.

- The 18 Spanish-speaking children who watched the program 5 days a week made the greatest group gains between the two testing periods.

- On the whole children who watched "Sesame Street" the most made the greatest gains.

- Skills that the program spent the most time on, such as learning letters and numbers, were learned the best.

- Children who watched the program at home showed slightly greater gains than children who watched the program at school.

To complement "Sesame Street," which first went on the air in the fall of 1969, the Children's Television Workshop is planning a program designed to teach reading skills to 7- to 10-year-old children. It will be presented to viewers in the fall of 1971. Both programs are supported by a combination of Federal and foundation grants.

For the deaf

To help profoundly deaf children develop communication skills, an instrument that translates sound into vibrations with distinctions perceptible by touch or pressure has been developed by a research team at the University of Illinois College of Medicine in Chicago, with support from the Children's Bureau from 1965 to 1968. The instrument, called General Auditory-Vibratory Experience Translator (GAVET), was designed by Shirley J. Heinze, Ph.D., research project leader, Raymond C. Blatt, and Paul Cekan, members of the departments of psychiatry

and otolaryngology. It was tested with nine deaf preschool children from the Chicago area in 1967 and 1968.

The children learned to use the GAVET by placing their finger tips against the transducer to sense the vibrations. Later they wore it on a head band against the mastoid bone, so that their hands were free for other activities. The research workers found that the GAVET stimulated vocalization in deaf children and helped them establish more natural speech patterns than such children normally achieve. Alternating the GAVET with a conventional hearing aid, or using the two together, helped the research workers overcome children's resistance to auditory and language training.

Among the disadvantages of the GAVET was the large size of one test model, which the children found uncomfortable to wear. The 2- and 3-year-old children were willing to wear a small model of the GAVET in the speech clinic and at home, but were reluctant to wear it in a classroom with other children where it set them apart.

The research team designed a model about the size of a body-type hearing aid, but the contractor did not finish it in time for use in the project.

Baby foods

On the basis of a study of the safety and suitability of salt in baby foods, a subcommittee of the Food Protection Committee of the Food and Nutrition Board, National Research Council, last September recommended that manufacturers of baby foods restrict the addition of salt to one-fourth of 1 percent of the food product. The recommendation was based on the finding that most infants receive substantially more salt in their diets than they require physiologically.

The study was undertaken at the request of the Food and Drug Administration in response to growing concern about the possible harmful effects of various food additives. The subcommittee found no evidence that the addition of salt to baby foods at present levels is either harmful or beneficial to healthy infants nor any evidence that it contributes to development of hypertension or other disease states in adult life.

In its report the subcommittee noted that manufacturers add salt to baby

foods to please the mother's taste, therefore suggested that adding small amounts of salt to baby foods might serve to control the total salt intake the infant by leading the mothers to serve such foods without further seasoning. It predicted that if manufacturers accept the recommended limitation added salt, the salt intake of most infants would be reduced from 33 to percent of current levels.

The subcommittee also reported the use of modified food starches, which it found "suitable and safe for use in foods for infants." Such starches added to strained and junior dinner desserts, and fruits to provide desired texture, consistency, and stability.

School lunches

On September 4, 1970, the U.S. Department of Agriculture put into effect new regulations regarding the national school lunch program to comply with the requirement of the National School Lunch and Child Nutrition Act of 1966 that all free or reduced price lunches provided with Federal financial or commodity assistance be served on a form anonymous basis.

Under the new regulations all schools that receive either money or commodities (or both) for their nonprofit school lunch service must serve nutritionally balanced free or reduced price meals to needy children who are determined eligible on the basis of family income, family size, and number of children in school and preschool.

As of January 1, 1971, the minimum income for eligibility must not be less than the standard set in Federal guidelines—for example, \$3,720 for a family of four in the 48 contiguous States but it can be higher.

Local schools must publicize eligibility standards by sending information to parents and mass media in the community. Schools also must provide simple application forms to all parents, and set up procedures for appeal from decisions on eligibility under a fair hearing procedure.

Children may not be required to pay for their meals, use a separate lunchroom, use special tokens or tickets, or otherwise identified or discriminated against.

Special Federal payments will be made to schools, according to their financial need, for lunches served to

at a reduced price to needy children
ating the school's publicly announced
eria.

Under the new regulations each State
st submit a plan of child nutrition
rations annually, outlining the
te's action program to extend the
ch program to every school in the
te, furnish free or reduced price
ches to all children eligible for such
ches, and utilize funds of the school
akfast program and the special food
vice program for children to reach
dy children.

school children

a community teacher program now in
fourth year in Rochester, N.Y.,
ngs certified teachers and mother-
es together in innercity homes to
rk with preschool children in devel-
ng cognitive, verbal, and perceptual
ls. Operated by the city school sys-
t to meet the special needs of the
advantaged center-city child for in-
ectual stimulation, the program cur-
tly serves 214 children between 3
1.5 years of age. It employs 11 teach-
and 40 mother-aides.

As a result of two special classes last
r, a new program has evolved that
ves emotionally disturbed and
ntally retarded children. This is in
dition to the regular program and is
ided by the Department of Health,
neation, and Welfare and Model
ies.

Groups of six to eight children meet
their own neighborhoods in the homes
the mother-aides for half-day ses-
ns twice a week. Teachers and
ther-aides who work with Spanish-
aking children are bilingual.

Eight of the teachers work with two
ups—one in the morning and a sec-
d in the afternoon. The other three
chers work with the special classes.
achers use techniques developed by
eiter and Englemann to improve the
ldren's language and communication
ls. At the beginning and end of each
r the children's achievemint is meas-
ed on the Caldwell Pre-School Inven-
y. In all areas tested, the children
ve made significant gains each year.
Mother-aides play a key role in the
home training program. Each aide
a paid paraprofessional, who assists
e teacher and also provides emo-
nal support for the children. Aides
eive in-service training and planning
child development and educational

techniques one-half day each week.
Such training has prepared many of
the mother-aides to expand their activ-
ities; they help the teachers recruit new
children and mothers; some have served
on a task force that evaluated the com-
munity teacher program and prepared
guidelines for selection and training of
new aides; and others have become
liaison agents with community action
groups.

When a child enrolls in the commu-
nity teacher program, he is given a com-
plete physical examination at Strong
Memorial Hospital and is referred to a
specialist for treatment of severe health
problems, if necessary. The community
teacher program also has a liaison
with the neighborhood health center,
which provides health services for chil-
dren in the program.

The program was supported for its
first 3 years with a Federal grant
awarded under title III of the Ele-
mentary and Secondary Education Act.
It is now supported through State
Community Education Center funds.
According to Charles A. Planz, the pro-
gram's former evaluator, the program
has been successful because teachers
come into a familiar home setting, be-
cause the children do not require trans-
portation and because the mother-aides
are directly involved in the children's
learning experience.

Miscellaneous

A pilot project to test the feasibility
of a computerized poison information
system is being undertaken by the U.S.
Public Health Service and the Chil-
dren's Medical Center in Boston, Mass.
Under the project, which began last
fall, the Boston Center's poison con-
trol unit is linked by computer with the
Food and Drug Administration's Poison
Control Division in Washington, D.C.
Technical assistance is being provided
by the National Institutes of Health.

When a child is brought to the Boston
unit for treatment after swallowing
poison, a request for information about
the suspected medicine or household
product is placed on the computer. Data
about the product's composition, effects
on children, and antidotes are retrieved
almost instantly from magnetic tape,
allowing the physician in Boston to de-
cide on appropriate treatment for the
poison victim.

FDA maintains such information on

file cards, and furnishes it on request
to a network of 560 emergency poison
facilities in hospitals and medical
centers.

. . .

The White House Conference on
Youth will be held at Estes Park, Colo.,
between March 29 and April 23. Dur-
ing that period, each of the 10 task
forces will meet separately to discuss its
studies and present recommendations
to groups of about 150 interested young
people and adults.

Task forces are currently conducting
inquiries on 10 major issues that con-
cern American youth: poverty; drugs;
environment; race and minority rela-
tions; education; the draft; the econ-
omy and employment; legal rights; for-
eign relations; and values, ethics and
culture. Each task force has eight young
people between the ages of 14 and 24
and eight adults as members.

. . .

The U.S. Office of Education is carry-
ing on a nationwide campaign called
Closer Look, with the goal of reaching
children with handicaps at an early
age. The campaign is designed to help
parents and guardians of such children
locate the educational programs their
children need.

The campaign has two parts: spot
announcements on television and radio,
which ask viewers and listeners to take
a closer look at their children; and a
computerized information center to dis-
seminate information about facilities
and special education programs that
can help children to overcome their
handicaps. (Special Education Infor-
mation Center, Post Office Box 1492,
Washington, D.C. 20013.)

correction

The editors apologize for an error
that crept into the article by Kenneth
M. Brinkhous, M.D. in the November-
December issue of CHILDREN, unbe-
knownst to the author. ("Changing
Prospects for Children With Hemo-
philia.") In speaking of laboratory
tests to detect carriers of hemophilia,
Dr. Brinkhous wrote: "One pitfall lies
in the fact that not all carriers have a
50-50 distribution between cells that
can and cannot produce the clotting
protein." The word "blood" inexplicably
and incorrectly appeared before the
word cells in the printed copy.

IN THE JOURNALS

Tomorrow's environment

Attitudes formed in children today will determine the success or failure of efforts to solve the environmental crises of tomorrow, says Matthew J. Brennan in the October 1970 issue of *Childhood Education*. ("Making Tomorrow Now: Building a Qualitative Environment for All Children.") The author, UNESCO International Director of the Venezuelan Conservation Curriculum Project, was formerly science specialist with the Office of Education, U.S. Department of Health, Education, and Welfare. He maintains that our schools are ill-prepared to assume the necessary task of developing in children an understanding of man's interdependence with all living things and his responsibility to maintain the environment.

"In most schools," he says, "the teacher is discouraged from using the surroundings as a laboratory. If he wants to take his class out-of-doors, he needs both parental permission and insurance against injury. Is it any wonder the average American knows little about his environment?"

The author suggests a new kind of environmental education that would create in children a sense of the beauty and wonder of nature, and an understanding of the importance of conservation in preserving all living things—including man himself. He urges that children be taught not only the basic scientific facts about the environment, but also the social and political factors involved in meeting today's environmental problems.

Children's feet

Twenty percent of nearly 9,000 pre-school and schoolage children examined for foot ailments in a 3-year screening project in the District of Columbia were found to have conditions serious enough to require treatment or further study,

according to an article in the September 1970 issue of *Public Health Reports*. ("Podiatry Screening Project for Children in the District of Columbia," by Jerome Shapiro, D.P.M., and Chu S. Rhee, M. A.) The project was carried out during 1967-69 by the District of Columbia Health Department in cooperation with the District of Columbia Board of Education and local podiatrists.

The authors report that postural problems—most frequently flat feet—and orthopedic disorders of the feet were found in 37 percent of the children screened, but not all such problems required treatment. Skin abnormalities of the feet were found in 16 percent of the children, gait deviations in 15 percent, and nail abnormalities in 4 percent. Nearly one-third of the children with orthopedic or postural disorders were found to be wearing ill-fitted shoes, as were one-fifth of the children without such disorders.

Of the 8,995 children screened, 997 were referred for treatment and 838 for additional study, according to the authors. Of those so referred, 409 had reported to the podiatry clinics of the health department by July 15, 1970.

The authors point out that such a screening project not only identifies serious foot ailments in many children but calls the attention of parents, teachers, and children to the importance of good foot care in the prevention of foot disorders in later life.

Educating disturbed children

In the October 1970 issue of the *Journal of Learning Disabilities*, Herbert N. Weissman, Ph. D., presents some considerations in providing instruction for disturbed children within a regular school system. ("Implications for the Education of Children with Emotional and Social Disturbances.")

The author reviews some broad diag-

nostic "grouping principles" as bases for planning for the child; determining whether the child's problem is caused by an organic disturbance or a functional disturbance with roots in experience; whether it has become internalized—and so not modifiable by simple changes in environment—or whether it is reactive to present environmental pressure; whether it results in suffering for the child or suffering for others; and whether it is partial or total. However, he warns against applying ideas of adult personality to a child who is in the process of developing and pointing out that in children "the boundaries between the abnormal and the normal are much more transitory and flexible than with adults."

The best learning setting for a disturbed child is in a regular classroom with outside therapy to maintain it there, the author asserts. Acknowledging that some children require placement in "contained classrooms for children with emotional disturbances" because of continuing disruptive behavior, he provides seven criteria for determining whether such a referral is necessary. These criteria range from degree of discrepancy between child's age and the appropriateness of his behavior to a consideration of child's total personality and degree of social adjustment.

Three groups of children found in contained classrooms—the undersocialized, the neurotic, and the psychotic—require different educational approaches, according to the author, in each case the pupil-teacher relationship is all-important and the aim must be to reject the inappropriate behavior but not the child.

Help for hemophiliacs

Home transfusions for hemophiliac patients are both practical and safe, report two physicians from Chicago Michael Reese Hospital in an article in the *New England Journal of Medicine* for November 5, 1970. ("Home Transfusion for Hemophilia," by Frederick Rabiner, M.D., and Margot C. Telfer, M.D.) The authors describe a program designed by their hospital hemophilia clinic to stop bleeding episodes in patients more quickly than possible when patients must be transported to the clinic—in some instances as far as 150 miles from their homes.

Under the program a member of the patient's family—usually the mother—trained at the clinic to ready a concentrated antihemophilic blood factor (AHF) preparation for transfusions and to inject it intravenously in the patient through the use of disposable equipment. After training, the home transfusionist is given a supply of the AHF for storage in the family's refrigerator or deep freeze (depending on the type of AHF in use). Whenever the patient suspects a hemorrhage, the transfusionist telephones the hospital's resident hematologist for instructions whether to give a home transfusion or, if so, how much or whether to bring the patient to the hospital. In the latter case, the transfusionist reports back the next day on the patient's progress.

Of 16 families, with a total of 18 patients, who volunteered to participate in the program during its first 18 months, 12 families, with 14 patients, are still participating at the time the article was written. According to the authors, the patients and their families are "universally enthusiastic about the plan" and believed that the patients' hemorrhages were treated faster, that their pain stopped sooner, and that their lives were less disturbed by disease than in the past.

While acknowledging it is too soon to expect objective changes, the authors express the hope that in shortening the time between onset of bleeding and AHF infusion and encouraging child patients to report suspected bleeding earlier, the program may ultimately reduce trauma and delay onset of chronic joint disease.

An avenue to self-respect

"The mass institution as it exists today definitely must be out," says Gisela Konopka, director of the Center for Youth Development and Research, University of Minnesota, in the October issue of the quarterly, *Social Work*. ("Our Outcast Youth.") In their stead she recommends two types of community-centered living arrangements: (1) small group homes for five or six young people each, located in accepting neighborhoods of cities and towns where the young people would go to school and take part in community life; and (2) small institutions with built-in educational and treatment services for not more than 25 young people who are not yet ready for "an everyday community situation," located near enough to centers of population to allow for some community involvement.

The author maintains that in spite

of reform movements in this and the last century, the sporadic appearance of innovative treatment techniques, increased knowledge about behavior, and "a great deal of talk about institutions as treatment facilities," the ancient concept of dealing with delinquents by casting them out of society still prevails in this country. Putting young people in large isolated institutions that emphasize conformity and obedience strips away their self-respect, she maintains.

Rehabilitation, the author insists, can only be built on self-respect and dignity. She offers five "musts" for any program that would bring this about. It must be community centered and so provide young people with a feeling of acceptance. It must involve a young person in his own fate through complete openness in dealing with him rather than with manipulative treatment. It must provide experiences of real accomplishment to enhance self-confidence. It must provide hope for the future through experiences of hope fulfilled. It must provide the young people with significant and positive relationships through their daily contacts with people their own age and with counselors who understand the need for providing outlets for the strong drives of adolescence.

READERS' EXCHANGE

BRINKHOUS: Two "ifs"

Dr. Brinkhous has written a lucid and encouraging account of recent advances in the technology of concentrate preparation for the treatment and prophylactic care of hemophiliacs. ("Changing Prospects for Children With Hemophilia," Kenneth M. Brinkhous, *CHILDREN*, November-December 1970). The scientific and engineering advances of recent years, which have brought these potent new means to the fore, now make possible a comparatively normal life for every young hemophiliac in the country—IF—and Dr.

Brinkhous does not duck these contingencies—our system of health care delivery can seek out sufferers and reliably provide services to those in need of them.

As in the case of other life-saving technologies — hemodialysis, organ transplants, and so forth—science has given us the tools, but we are as yet far from translating them into policy commitments, much less into effective organizational and financing structures for their equitable use. What mechanisms exist for distributing presently scarce medical resources effectively and equitably? Dr. Brinkhous addresses

himself to two in the case of hemophiliacs: improvements in private health insurance coverage; and governmental programs such as the Federal-State Crippled Children's Services (when will that horribly anachronistic name be changed?) and Medicaid.

I believe it unrealistic to expect commercial insurance carriers to write policies providing prophylactic and therapeutic transfusion care for *known* hemophiliacs, even if the costs of cryoprecipitate preparations could be substantially reduced.

Present governmental programs of care for eligible categories of patients, as Dr. Brinkhous implies, suffer from chronic financial shortages, political pressures, and the enormous variations in adequacy and coverage from State to State.

To my mind, only a truly national

and comprehensive program of health insurance—as proposed in bills before the present Congress—could provide the financial and organizational foundation to support a hemophilia transfusion and treatment service that would incorporate the benefits of concentrate technology, and provide prophylactic and remedial care to all hemophiliacs in need of it. Our northern neighbor, Canada, has already taken significant steps in the direction of making the concentrates generally available to hemophiliacs.

The costs of preventive care, while high, are less—in both human and material terms—than the costs of rehabilitation—of righting damage once it has occurred. As stated in my recent book:

"Hemophilia is not a disorder of such medical magnitude that, like mental disorder or tuberculosis, it would require a very expensive national or State-supported program of care, although the treatment costs are nearly always beyond the income of families with hemophilic members. The absence of a well-planned, preventively oriented care program has serious consequences. Hemophilia is a disorder where the failure to treat early and decisively increases the frequency of severe impairments. For example, many State vocational rehabilitation services could begin before impairment and work on a preventive basis. This would mean getting to the children and their parents with a planned program of physical care and psychosocial counseling, through the cooperation of State Crippled Children's, vocational rehabilitation, and other public and private agencies." (*Hemophilia: A Study in Hope and Reality*, published by Charles C. Thomas, 1970.)

Such a preventive approach might also reduce the overall costs of care by making it less necessary to provide preventable physical rehabilitation.

Alfred H. Katz

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PEARSON: No panacea

I was fascinated by the article, "A Differential Use of Group Homes for Delinquent Boys," by John W. Pearson (*CHILDREN*, July-August 1970). The article started out in a stimulating way,

talking about classification, matching of the delinquents' and parole agents' personality traits, planning of an individualized treatment program and use of relationship as a major agent of change. However, I was stunned to learn late in the article that all of the group homes had terminated for various reasons.

Since group homes are looked at as something of a panacea for children's placements, I think that this article is timely and calls for a lot of soul searching by agencies planning or carrying on such home programs. It appears to me that we must realize that we are expecting too much of some group home houseparents. We have prided ourselves in the institutional field on giving lighter work schedules and ancillary personnel to help the child care staff.

We have developed creative activity programs, work opportunities for children, much community contact, and even individualized rooms. I wonder what group homes have to offer some young people in such therapeutic programs. One can find in the literature much pride that group homes are inexpensive. Perhaps that it is because we are taking advantage of group home houseparents, and have returned them to an era of little pay and excessive hours of work. If group home programs are to succeed, group home houseparents have to have an agency demonstrate respect through pay, status, support, and understanding. They cannot be expected to be miracle workers for young people who are not ready to really relate to the community in a positive manner.

I would welcome comments and letters from other readers who have some questions about the group home movement in the United States.

Spencer J. Allen

*Executive Director
GATEWAY
Williamsville, N.Y.*

EDINGER: A missing ingredient

In reference to Hanni Edinger's article "Reuniting Children and Parents Through Casework and Group Work" (*CHILDREN*, September-October 1970), I would like to indict this effort in social work research with what I consider to be gross malpractice. In the "assessment" portion of her article she cites social workers' testimony as sup-

port for the alleged effectiveness of the project.

It is not timely to suggest in this era of consumers' rights, and in this case the consumers are the clients, that we should pay more attention to the client perceptions of the effectiveness of our professional efforts? How much longer are we going to delude ourselves in thinking that in the absence of client criticism we are doing a fine job?

My criticism of course goes beyond this one article, but there are few words from the clients in Hanni Edinger's "assessment," and although these words acknowledge client approval of the project's effectiveness, they are obviously added as an afterthought.

I am reminded in this article of me of the same old, "I'll scratch-your-back-if-you'll-scratch-mine" kind of social work research that is certainly of little value in scientific knowledge-building upon which social workers may hope practice.

Owen D. Spe

*Supervisor of Social Services
Neosho County Social Welfare
Chanute, K.*

Author's reply

If Mr. Sperry took another look at my article, he would note that (1) purpose was to share our experience in a parent group at St. Christopher School because few reports of such projects have been published; and (2) made no claim to have conducted a search project. Rather, as stated in conclusion, we felt that "controlled experiments are needed. . . ."

I couldn't agree with him more that clients' critical involvement in social work process is essential. In the case at least, the proof of the pudding was in the eating: parents did return for more group meetings.

Hanni B. Edinger
Dobbs Ferry, N.Y.

photo credits

Frontispiece and page 4, White House Conference on Children.
Page 11, Bernie Boston for Head Start.
Page 26, Del Hood, *The Daily Californian*.

U.S. Government Publications

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YOUTH REPORTERS DISCUSS PROBLEM" DRUGS. Elizabeth Herzog, Cecelia E. Sudia, Jane Harwood. HEW, OCD, Children's Bureau. Youth Reports No. 2. 1970. 46 p. Single copies free from OCD.

Presents the opinions and attitudes expressed in a nationwide mail survey of high school students in college preparatory curricula concerning the use of users of drugs.

TEACHING READING DIFFICULTIES: the role of the principal, teacher, specialist, administrator. HEW, Office of Education, National Center for Educational Communication. OE publication No. 30026. 1970. 32 pp. \$1.50.

Describes the role of the school principal, the teacher, the reading specialist, and the school administrator in working together as a team to correct reading deficiencies in children in kindergarten through twelfth grade.

HEW refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; SRS, to Social Rehabilitation Service; PHS, to Public Health Service.

STATISTICS IN MENTAL HEALTH PROGRAMS. Edited by Cecil R. Wurster. HEW, National Institute of Mental Health, National Clearinghouse for Mental Health Information. 1970. 65 pp. 65 cents.

Contains 12 papers presented at the 1967, 1968, and 1969 meetings of the National Conference on Mental Health Statistics. Among other aspects of statistical use they discuss the application of data systems to program evaluation methods and program planning methods for measuring service needs and patient change.

SELECTED READING SUGGESTIONS—for parents of mentally retarded children. Compiled and annotated by Kathryn A. Gorham. HEW, OCD, Children's Bureau. CB Publication 19. 1970. 58 pp. 60 cents.

Contains annotated listings on mental retardation; associated conditions; managing, educating, and protecting the future of the retarded child; and related subjects.

THE SIX-HOUR RETARDED CHILD: a report on a conference on problems of education of children in the inner city, August 10-12, 1969, Warrenton,

Va. President's Committee on Mental Retardation and Bureau of Education for the Handicapped, Office of Education, HEW. 1970. 28 pp. 35 cents.

Briefly summarizes the conference and presents its seven recommendations for improving the educational opportunities of children labeled retarded although they are "competently coping with their environment everywhere but for the six hours per day in the classroom."

MINIMAL BRAIN DYSFUNCTION IN CHILDREN: educational, medical, and health-related services. HEW, PHS. PHS Publication No. 2015. 1970. 81 pp. \$1.

Presents the report of a task force on the National Project on Learning Disabilities in Children, including evaluation and assessment, classroom management, professional preparation, and educational legislation.

CENTRAL PROCESSING DYSFUNCTIONS IN CHILDREN: a review of research. James C. Chalfant and Margaret A. Scheffelin. Institute for Research on Exceptional Children, National Institute of Neurological Diseases and Stroke. NINDS Monograph No. 9. 1970. 148 pp. \$1.25.

Summarizes the present status of knowledge in and the future research needs for identifying, assessing, and treating children with central processing disorders arising from minimal brain dysfunctions.

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CHILDREN

INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

march • april 1971

White House Conference priorities
adoption resources for black children
assets and liabilities of day care
group service for unmarried mothers



CHILDREN

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Father and son—made so through adoption. Inter-racial adoptions, which have been increasing in recent years, have been encouraged by some agencies as one method of finding permanent homes for otherwise homeless black or racially mixed children. At the same time intensive efforts are underway to step up home-finding among black families. (See article beginning on page 49.)

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SELECTING PRIORITIES at the WHITE HOUSE CONFERENCE on CHILDREN

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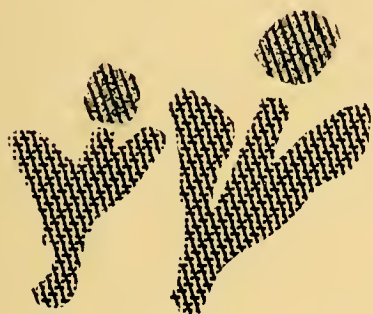
KATHRYN CLOSE

The need for "comprehensive family-oriented child development programs including health services, day care, and early childhood education" topped a list of 16 "overriding concerns" identified at the 1970 White House Conference on Children, December 13-18, and transmitted to President Richard M. Nixon early in January by the Conference chairman, Stephen Hess. Next to the top was a concern for "the development of programs to eliminate racism which cripples all children."

Along with the overriding concerns went a list of 25 specific recommendations from the Conference forums led by a call for "a reordering of national priorities" to "provide opportunities for every child to learn, grow, and live creatively."

The overriding concerns and the specific recommendations as sent to the President are presented in this issue on pages 44 and 47. Their order follows the results of balloting by the delegates on the final day of the Conference.

More than a year's work and a great deal of energy went into the forging of these recommendations and concerns: innumerable meetings of staff and advisory committees to select the chairman, vice chairman, 16 members of the planning groups of the 25



ference forums—groups charged with preparing preliminary reports and planning the Conference meetings on specific subjects;¹ at least three preconference all-day meetings of each planning forum; and days of listening and discussion by the delegates at the Conference—at an opening plenary session, forum meetings (enlarged by the addition of delegates to about 160 persons each), small work groups of 10 to 15 people, more or less organized caucuses or special interest groups, rump “plenary sessions,” and innumerable impromptu “bull sessions” in hotel rooms, corridors, and lunch rooms.

About 5,000 persons attended the Conference, of whom 3,700 were voting delegates and the rest observers from foreign countries and international organizations, Government resource people and readers, and White House Conference staff members and guests. Of the delegates, more than 1,700 were elected by the 50 State Governors through their state committees on children and youth, 1,000 by professional and national voluntary organizations, 300 by Members of Congress, and 300 by the Conference staff from lists of non-affiliated groups; and 1,000 were members of Conference committees.

Getting an overall perspective on anything as big as a decennial White House Conference on Children is difficult if not impossible. One's impression is there-

fore largely shaped by what happens in the group one happens to be assigned to or elects to follow, by the people one talks to, and, certainly not least, by the expectations one brings along.

In this conference the delegates who came to learn and to work did just that, judging by the lively interplay in many of the small work groups and forum sessions. Those who came to grind axes ground them hard—and some did so apparently without bothering to attend the working sessions. Nevertheless, there were rich opportunities for those who would seize them: a chance to listen for those who wanted to learn what others, including the President of the United States, are thinking, doing, and planning to meet the needs of children; a chance to work with others in hammering out priorities for action; a chance to express a point of view; a chance to get a glimpse into the minds of children as revealed through their art work and movies made by or about them; and a chance to go back home with renewed determination to work in behalf of children and new ideas on how to proceed.

In a sense this was as much a teaching as a working conference. The preconference forum reports and their presentation through audiovisual materials, socio-dramas, role playing, visits to exemplifying sites in Washington, and various other audience participation exercises demonstrated many of the problems hampering the optimum development of children today and suggested ways of dealing with them. In a few forums, Government dignitaries from Congress and the executive branch spoke on the need for widespread public support to enhance the possibility of greater Federal participation in programs to meet the needs of families and children, especially for income maintenance, family planning, and developmental child care. Children's exhibits of art, music, film-making, dance, and gymnastics demonstrated the potentials of children for creative expression. The commercial exhibits presented a myriad of child-oriented products of the new technology—for example, a research-storing and information-divulging computer, teaching machines of various kinds, educational toys, changeable room dividers, a car safety belt especially designed for children.

The President speaks

In addressing the Conference as a whole on opening night, President Nixon identified its concern as “the well-being of 55 million individual human beings who happen to be children under the age of

OVERRIDING CONCERNS of the White House Conference on Children

in order of priority voted at the Conference through a system giving weight to each voter's ranking. (The number in parentheses indicates rank by first-place votes only.)

1. Comprehensive family-oriented child development programs including health services, day care, and early childhood education. (3)
2. The development of programs to eliminate the racism which cripples all children. (2)
3. Reordering of national priorities beginning with a guaranteed basic family income adequate for the needs of children. (1)
4. Improve Nation's system of child justice so law responds in timely, positive ways to needs of children. (11)
5. A federally financed national child health care program which assures comprehensive care for all children. (6)
6. A system of early identification of children with special needs which delivers prompt and appropriate treatment. (10)
7. Establishment of a child advocacy agency financed by the Federal Government and other sources with full ethnic, cultural, racial, and sexual representation. (8)
8. Establish immediately a Cabinet post of children and youth to meet needs of all children. (4)
9. Health, welfare, education, and bilingual-bicultural growth of all children must be given top priority. (7)
10. Immediate, massive funding for development of alternative optional forms of public education. (9)
11. A change in our national way of life to bring people back into the lives of children. (5)
12. Elimination of racism demands many meaningful Federal programs, particularly an adequate family income maintenance floor. (12)
13. A national land-use policy must be developed to guarantee the quality of leisure services, social services, and our Nation's natural resources for all children. (15)
14. Universal developmental child care without sex role stereotyping will help to eliminate institutional, individual sexism. (16)
15. All institutions and programs that affect children must involve children as active participants in the decisionmaking process. (13)
16. The Indian representatives of this Conference recommend that all levels embark on a vigorous practical approach to enhance the future of our children. (14)

14—and who represent one-fourth of our country's total population." He reminded the delegates that "nothing is so intensely personal as the private world of a child" and asked them to remember that no two children are alike and "what is right for one child may be all wrong for another."

Maintaining that the Government must play a vital role in ensuring the best possible opportunity for the child, the President urged the conferees to support congressional enactment of his family assistance plan, which would "establish a floor under the income of every American family with children."

The President called the present system of assistance, in which 6 million children are involved, "an

unfair and tragic system that rewards people for not working instead of providing the incentives for self support and independence, that drives families apart instead of holding them together, that brings welfare snoopers into their homes, that robs them of pride and destroys dignity."

"This sort of indignity," said the President, "is hard enough on the mother—enough of a blow to her pride and self-respect—but think what it must mean to a sensitive child."

The President also stressed the importance to all children of opportunities to participate in efforts to improve the country's well-being. "We have got to let 55 million very young Americans—as well as those

little older—know that what they *do* matters, that their ideas do count, that the country needs their thoughts, their creativity, their contribution.”

Working sessions

The President’s address was the only formal speech made to the Conference as a whole. In fact, the opening session was the only official plenary session. During the rest of the week the delegates met in “clusters,” in forums, and in small work groups. The six clusters, composed of three to five forums each were focused on individuality; learning; health; parents and families; communities and environments; and laws, rights, and responsibilities. Each forum dealt with specific aspects of these subjects. For example, the parents and families cluster consisted of forums on “changing families in a changing society;” “children and parents—together in the world;” “family planning and family economics;” “developmental day care services for children.”

Most clusters met twice—in an introductory session Monday morning to present an overall “state of the Nation” picture of its topic, and in a final meeting Friday morning when the overriding concerns and forum recommendations were presented and the balloting took place. After presentations in the introductory cluster, the forums met separately for further presentations related to their specific topics and for discussions, both in small work groups and in the forums as a whole, that led to the recommendations finally drawn up. The delegates from the four forums in the cluster on law, rights, and responsibilities, for example, watched a long, moving film depicting the societal and family neglect that drive children to delinquency and the inadequacies of detention facilities and rehabilitation services. At a subsequent meeting of the forum on “children in trouble” several young people who had parts in the film—playing themselves—brought the discussants firsthand testimony of what goes into the making of a delinquent, most particularly the feeling “nobody cares.”

While the recommendations in the preconference forum reports were the basis of the delegates’ discussions, the delegates obviously did not see themselves as rubber stamps. They brought ideas to the forum and work group discussions, argued with each other, raised questions, demanded elucidation. “When you talk about population control we want to be sure you’re not talking about control of the black population alone.” “If by educational experimental

tion you mean voucher payments to attend private schools, what happens to accountability?” “Why don’t we say something about institutional racism since it can be attacked more easily than the racism in the minds and hearts of people?”

The January-February issue of *CHILDREN* presented some of the recommendations of the preconference reports and some of the common threads of interest that ran through many of them—drastic educational reform, a system of advocacy for children, greatly expanded health services, a reordering of priorities to put children’s needs at the top of national concerns.¹ Implicit in most of these reports, and explicitly stated in a few, was the assumption that racial discrimination must go, but only one such report suggested a series of specific steps toward its elimination.²

Throughout the Conference, however, delegates repeatedly expressed a determination that discrimination against racial and cultural minorities must be attacked on all fronts. Representatives of racial and cultural minorities—and of women—formed caucuses that came up with resolutions of their own. The largest, the “black caucus,” sponsored an unscheduled open “plenary session” at which several

One of the workgroups in the forum on identity finds its own group identity by creating an “igloo” to set it apart from the other forum members during the small group discussions.



recommendations were passed by voice or hand vote. The Conference chairman agreed to transmit these to the President.

Another achievement outside the official Conference schedule was the organization of a Children's Lobby—a recommendation in the preconference report of a forum on “crisis in values” that came to fruition at an open meeting called by Jule M. Sugarman, administrator of human resources for the city of New York. [See page 77.]

Another unofficial plenary session was sponsored by some members of the Council of National Organizations for Children and Youth. This turned into a confusion of apparently unrecorded resolutions when its plans for proceeding were overthrown by representatives of the black and Chicano caucuses.

But the work of arriving at the overriding concerns and specific forum recommendations took place within the Conference machinery and grew logically from the recommendations in the preconference reports, rejected or selected and refined in the work group and forum sessions.

Ten of the overriding concerns presented to the delegates at their final cluster sessions for balloting regarding order of priority were selected at a meeting of the cluster chairmen from a list of recom-

mendations presented them by the forum chairmen as a result of 2 days of forum and work group meetings; the other six were submitted as a result of petitions signed by at least 200 persons. The “specific forum recommendations” on the ballots consisted of one recommendation from each forum (except forum 1) voted at its last meeting.

A total of 1,912 delegates, or 52 percent of those eligible to vote, turned in ballots. The final ranking of the overriding concerns was determined by the number of points received in a voting system in which the voter's first choice counted as 16 points, his second choice 15 points, and so on down. The ranking of the forum recommendations was determined solely by the number of votes cast for each recommendation.

Backup statements

The Conference rules required the overriding concerns and forum recommendations to be stated in no more than 15 words. Therefore, when submitted to the delegates for voting, each was accompanied by a backup statement explaining its meaning in greater detail and giving some rationale behind it. For example, the backup statement accompanying the concern for “comprehensive family-oriented child development programs” specifically asked that Federal funding of such programs be made available “immediately for the first year for spaces for 500,000 children, increasing 250,000 spaces a year until service reaches all families seeking it and all children needing it. Such programs, the statement said, should be “family-centered, locally controlled and universally available” and should “provide for active participation of family members in their development and implementation.”

The backup statement regarding the concern for programs to eliminate racism was less specific about financing and program details, calling only for “mechanism of education to assist people to become aware of their racism and to begin to rid themselves of it.” Distinguishing racism from racial segregation, “which can be at least partially dealt with by direct Government intervention,” it called racism a social disease that is “far from being unrooted from the hearts of the American people. Conquering racism, according to the statement, requires “immediate attention by all levels of government and serious self-examination by every American.” “The tragedy is that we are unaware of our feelings of superiority or inferiority.”

A group of Conference guests on Thursday afternoon, when the exhibit hall was open to the public and special events for children were staged—a puppet show, a “live” demonstration of “Sesame Street,” music, dancing, and gymnastics.



THE 25 FORUM RECOMMENDATIONS of the White House Conference on Children

in order of priority voted by Conference as a whole

1. Provide opportunities for every child to learn, grow, and live creatively by reordering national priorities.

2. Redesign education to achieve individualized, humanized, child-centered learning. We support the proposed National Institute of Education with this goal.

3. Establishment of citizen community action groups to implement the multitude of excellent recommendations which have evolved out of this White House Conference on Children.

4. Reform justice system; emphasize prevention and protection; replace large institutions with small, home-like facilities.

5. Rights of children, including basic needs and education, require legal and other accountability of individuals and agencies responsible for providing them.

6. Establishment of a child advocacy agency financed by the Federal Government and other sources with full ethnic, cultural, racial, and sexual representation.

7. A federally financed national child health care program which assures comprehensive care for all children.

8. To enhance the self-worth of all children, and to achieve early population stabilization, we recommend consumer-determined, publicly funded programs of (1) family life, sex and population education, and (2) voluntary family planning services and safe abortion available to all.

9. Resolved: The President immediately and unequivocally express his commitment to enforce existing legislation to end racism and discrimination.

10. The establishment of a Department of Education with Cabinet status, backed by a National Institute of Education.

11. Establish immediately a high-level, independent Office of Child Advocacy, with a network of local advocacy.

12. Department of Family and Children with Cabinet status: State and local councils, all adequately funded.

13. Comprehensive developmental programs for handicapped or potentially handicapped children from birth to 6 be mandatory.

14. The United States can and must drastically re-

duce injuries—perinatal, traffic, poisoning, burns, malnutrition, rats—and provide health and safety education.

15. Quality developmental child care requires thoroughly trained personnel and parent and community control of programs.

16. Federal support for independent research and dissemination of information on existing and alternate forms of education.

17. Establish a people-oriented National Institute for the Family for action, advocacy, implementation, legislation, and research.

18. A federally financed national child health care program which assures comprehensive care for all children.

19. The right-to-read effort be established as a top national priority supported by special legislation and funding commensurate with its critical importance.

20. Promote expressions of identity through physical-emotional identity learning, parent education, and an international children's year.

21. It is essential for a national body to be formed to assure the implementation of the recommendations of the 1970 Children's Conference.

22. That these words be included in the Pledge of Allegiance to the flag: ". . . stands; and *dedicate myself to the task of making it one nation, . . .*"

23. That cross-cultural, participating experiences must be provided for *all* children so they may understand the concepts and goals of justice in terms of human relations; and that community decisionmaking processes and educational experiences must provide for the participation and knowledge necessary for a personal, realistic commitment to the democratic system.

24. Establish a national task force to develop an Office of Leisure Services at Federal and State levels.

25. In an effort to begin the process of improving the quality of life for children (some of whom we can each call by name), the members of Forum 20 (Child Development and Mass Media) are making such recommendations as to affect and implement many concerns regarding humane human development and the mass media. We are unwilling to suggest the relative dispensibility of any one of our recommendations. They are all urgent and affordable.

Ways of "reordering national priorities," called for in the overriding concern voted as No. 3, were spelled out in its backup statement. This asked that during the next decade the proportion of the Nation's gross national product devoted to public expenditure for children and youth be increased by at least 50 percent, and that the proportion of the Federal budget devoted to children be at least doubled. It also recommended that "support for families be provided to the family as a *unit* without prejudice against variant family structures and with recognition of differing cultural values and traditions."

Specific measures needed to improve "the Nation's system of child justice" were included in the backup statement for the overriding concern voted as No. 4. It called not only for "more and better trained judges and staff" and available community resources—small community-based care facilities, foster homes, group homes, and day care—but also for a "complete restructuring of child and juvenile laws" to provide "laws which emphasize not guilt or innocence," but which "aid and guide" those who come to the law's attention, "humanize, not stigmatize" and "improve the quality of family life." It stressed the importance of "full due process and legal safeguards" for children who must be involuntarily confined and of such confinement being in "homelike institutions staffed with competent, concerned persons dedicated to care and not to storage and punishment."

The backup statement for the concern voted fifth in order of priority—a "federally financed national child health care program which assures comprehensive care for all children"—called for a system of reimbursement and prepayment "designed to create incentives for more rational, organized, and efficient systems of health care delivery which stress illness prevention and health promotion." It also called for allocations from budgets of present Federal child health programs to help finance new resources in areas of critical need.

The backup statement for the top priority forum recommendation, calling for "opportunities for every child to learn, grow, and live creatively," spelled out these opportunities as the "development in each community of total educational programs available to every child through a more diverse and flexible educational system, more creative approaches to learning, a stress on early childhood education, the expansion of cultural and creative learning centers, and the integration of aesthetic education in every school, institution, and agency which serves children."

A full report of the Conference will soon be forwarded to the President as well as to each of the Conference delegates. It will include all of the forum recommendations—and there were many more than the 25 submitted in the list of priorities.

Followup plans

What next? Who will work to convert the Conference recommendations and overriding concerns into action? Without some definite strategy for followup the stimulation of conferences tends to fade when delegates get back home to the demands of their daily tasks. One of the forums of this conference—forum 26—worked all during the week to develop followup strategies. It recommended, among other steps, the formation of a national body to implement the Conference's recommendations. (Recommendation 2, page 47.) A move in this direction has already been taken by the Department of Health, Education, and Welfare in allocating \$300,000 of its 1972 budget for a followup staff and activities. This staff is committed to work with State committees, national organizations, and Federal agencies toward fulfilling the recommendations that interest them and to report to the President by June 30, 1972, on what has been accomplished. The Office of Child Development through the Children's Bureau's National Center for Child Advocacy will carry the major responsibility for the followup activities.

In the meantime, before this issue of *CHILDREN* is off the press, conferences to develop strategies for followup action in States and communities will have been held in five cities—Omaha, Nebr.; Seattle, Wash.; Indianapolis, Ind.; Atlanta, Ga.; and Denver, Colo. These conferences are being sponsored by the National Committee of State Committees for Children and Youth in conjunction with the White House Conference, and their participants—about 25 each—are for the most part representatives of State committees, who are in strategic positions to get action underway in their States and local communities.

¹ Epstein, Noel: Priorities for change—some preliminary proposals from the White House Conference on Children. *Children*, January-February 1971.

² White House Conference on Children: Children without prejudice. Report of Forum 18. Washington, D.C. 1970. (Mimeographed.)

adoption resources for black children

URSULA M. GALLAGHER

The large number of adoptions in this country attest to the general acceptance of adoption as a way of bringing loving care to children in need of families of their own and the satisfactions of parenthood to childless couples and others who have room for one more. In 1969, an estimated 171,000 adoptions were completed; of these, 52 percent were of children placed with persons unrelated to them. In this group of nonrelative adoptions, 89 percent of the children had been born out of wedlock, 5 percent had been placed by social agencies, and 6 percent were white.

White infants in normal health are readily placed for adoption. In fact, social agencies are reporting a decrease in the number of white infants for whom adoptive placement is needed and at the same time an increase in the number of adoptive applicants for each child.

However, for some children there is a serious shortage of adoptive applicants. These include children of minority races or those of mixed racial background, older children, children with physical or emotional handicaps, and groups of children from the same family. More children in these categories are being placed for adoption each year, but thousands remain in need of permanent homes. Most of those for whom homes have not been found are black or of mixed black and white origin.

A recent study by the Child Welfare League of America has shown that for every 100 white children awaiting adoption, there are 116 prospective adoptive homes while for every 100 nonwhite children awaiting adoption, only 39 prospective homes are available.¹ About 40,000 nonwhite children are estimated to be in need of adoption.

There are, of course, geographical differences in the availability of homes and of children. For this reason the Child Welfare League of America has es-

tablished the Adoption Resource Exchange of North America (ARENA) to bring children for whom adoptive parents cannot be found in their home areas to the attention of adoption agencies in other areas where potential adoptive parents may be available. Agencies register with ARENA the names of children who are waiting to be adopted and the names of approved families who are waiting to receive a child.

Flexible requirements

To help meet the gap between the number of children with special needs awaiting adoption and the number of prospective adoptive homes, most agencies have become more flexible in their requirements for adoptive parents. While basic standards necessary to insure good care and child development remain unchanged, many applicants who would have been turned down a few years ago are now given an opportunity to adopt. These include families in which the wife works, older couples, couples with very limited incomes, couples who already have children, especially qualified single persons, foster parents, and handicapped persons whose handicaps do not seriously affect their child-rearing capacities.

In determining whether to approve a working woman as a prospective adoptive mother, the adoption agency considers whether she has an adequate child-care plan during her working hours and also whether she will have the capacity to provide mothering to the child after working all day, perhaps at a tiring and frustrating job. Job satisfaction is important to allow the mother a reservoir of energy for attention to the child.

While few agencies still set age limits for all adoptive applicants, the age of the applicants does have to be considered when the child to be placed is an infant, for the parents' ability to care for him as

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he grows older has to be taken into account. Similarly, any medical problem the applicants might have also has to be considered in the light of its effect upon obligations of parenthood.

Unfortunately many persons, particularly in minority groups, believe that agencies only accept applicants who own their own homes and have substantial bank accounts. Actually, the amount of the family's income is not a decisive factor in an adoptive home study, but rather the family's ability to manage money and the breadwinner's steadiness in employment.

Sometimes families have a great deal of affection and security to offer a child, but cannot afford to take on total financial responsibility for an additional member. Therefore, a policy of subsidizing such families after adoption increases the number of available homes. Seven States have passed legislation permitting a subsidy from tax funds to some families that have adopted children—California, Illinois, Maryland, Michigan, Minnesota, New York, and South Dakota. Some of these States are now beginning to implement such legislation. Although their regulations differ, all require that the subsidy plan be arranged before the adoption is completed and all set a limitation on the amount of the subsidy. A few set a maximum family income for eligibility for the subsidy. Some limit eligibility to couples who are adopting their former foster child. Subsidies may be for a short time, a long time, or an indefinite period, according to the individual family's need. Voluntary agencies, particularly the Chicago Child Care Society, have taken the lead in providing subsidies.²

Foster parents are usually chosen to care for a child on a temporary basis until the child can return to his own parents or go into adoption. Many foster parents who provide excellent interim care might not make suitable adoptive parents for the child placed with them because of their age, their very limited incomes, health risks, or other reasons. In some cases,

however, particularly where the child becomes available for adoption after he has put down roots in the foster parents' home, it is logical for the foster parents to become the adoptive parents.

Sometimes agencies have denied foster parents an opportunity to adopt, and this has stirred up public indignation. Occasionally the agency has been in error. However, even when the decision has been right, agencies have withheld the facts on which it was based to protect the confidentiality of personal information given by the foster parents themselves. In some of these instances the agency had let the child stay in the foster home longer than originally intended because of difficulty in terminating parental rights or reluctance to upset a situation that was satisfactory for the time being although not likely to meet the child's needs as he grew older.

Single-parent adoptions, usually by a woman but occasionally by a man, are comparatively recent and are reported to be a successful way of finding homes for some children who otherwise would not attain adoption. They require careful screening of applicants, especially in relation to motivation for adoption, attitudes toward methods of child rearing, and opportunities for the child to get to know adults of both sexes. Since the adoptive parent is likely to be a wage earner, unless a subsidy is granted, special attention has to be given to both the stability of her income and her child care plan. In one large city publicity about an agency's change of policy to allow for single-parent adoptions not only attracted many single persons as applicants for children but also couples.³

Transracial adoption

Transracial adoption has in recent years become an expanding resource for the placement of children for whom no adoptive parents of their own racial background have been found. The first moves in this direction involved Asian children brought to this country for adoption after the Korean war. Since 1956, thousands of orphaned or abandoned children have been brought by voluntary organizations to the United States for adoption from Korea, Japan, Taiwan, Thailand, Hong Kong, and, more recently and in fewer numbers, South Vietnam. Most of these children have been adopted by Caucasian families. Several followup studies have indicated that on the whole they have adjusted well.^{4, 5}

Another experience in transracial adoptions has been provided by the American Indian adoptive

project sponsored jointly by the Child Welfare League of America and the Bureau of Indian Affairs, Department of the Interior. Between 1958 and 1968, agencies cooperating in this project placed nearly 400 Indian children for adoption, most of them with Caucasian families. A number of tribes disapproved of the idea of transracial placement but participated in the project because of their inability to find Indian adoptive parents. A study of these adoptions, now in process, is scheduled to be completed by September 1971.

More recently, adoption agencies in this country and Canada⁶ have been placing black children or children of mixed black and white origin with white families. In a nationwide survey conducted by an Oregon organization called Opportunity, 342 agencies reported adoption placements in 1969 of nearly 1,000 black children and children of mixed black-white parentage; one-third of these placements were made with white families, as compared with about one-fourth of the placements of such children made in 1968.⁷

A study of characteristics of 186 white couples who have adopted black or racially mixed children has shown them to be of a higher socioeconomic level than most families, to have religious or humanitarian motives, and to be isolated from their families and detached from their communities.⁸ A majority of the couples believed it to be more difficult to rear a child of another race than one of their own race.

In another study involving 147 couples and two single women who had made such transracial adoptions, the adoptive fathers were found to have a high degree of ego strength and the mothers to have liberal child-rearing attitudes.⁹

A similar study involving 24 couples found that most of the fathers were professional persons and most of the mothers were concentrating on child-rearing and not working outside the home.¹⁰ Still another study of couples who adopted across racial lines is in process in Michigan.¹¹

Strengths needed

A psychiatrist recently observed that the best adopters of children of another race are likely to be couples who are not ethnocentric—that is, do not put more value on children of their own race than on other children.¹² Certainly a thoughtful consideration of their own feelings and unqualified agreement between husband and wife before applying for a child of another race are of primary im-

portance to the well-being of the child. Preparing themselves to deal with various reactions on the part of their parents, other relatives, friends, and neighbors may help the couple understand their true feelings and increase their ability to cope with some inevitable negative responses. How will they deal with censure by a close relative? How will they feel when they are stared at while walking down the street with their black child? Will they be embarrassed when they register the child in school? If the child is taunted by his white playmates, will they be able to help him in a calm way? When the child becomes old enough to understand, will they be able to talk to him comfortably about being adopted and help him feel that he is a secure member of the family in spite of his different appearance?

Some people might think that telling a black child whose parents are white that he has been adopted is unnecessary. However, the child might be puzzled and confused if the parents fail to deal with the matter directly. Actually, the difference in appearance might make it easier for both the parents and the child to accept the fact that the child was not born into the family. In discussing this fact with the child, the parents need to feel glad that they adopted the child, strong in their love for him, and able to deal with whatever questions he may have about his biological parents as individuals as well as members

A family looks over its newest member in the office of the adoption agency from which it has just received the baby.



of a different race from that of the parents he knows and loves. The adoptive parents' feelings for their child and their acceptance of reality will have more meaning than the words they use.

As in all adoptions, the adoptive parents in a transracial adoption must be cautious in handling a child's questions about his biological parents. In addition, they must appreciate the strength and richness in the black cultural heritage. If they feel hostile toward the child's biological parents or superior to them or their race, the child may develop feelings of inferiority. They may also make him feel inferior by indicating in any way that they have done "a great thing" in adopting him. No child should be put in the position of feeling he should be grateful for having been saved from "a terrible fate" through adoption. Adoptive parents who look for gratitude are suffering from what has been called "the rescue fantasy."

Many adoptive parents resent being praised for "doing a wonderful thing" by adopting a child. Such resentment is a sign of a healthy attitude, for surely they, too, are gaining satisfaction from the adoption. While the focus in placement must always be on the welfare of the child, the needs of the child and of the adoptive parents are always interwoven.

The focus must remain on the child and his welfare for his whole life, not just for today. In the course of growing up, every child will face problems. Different stages of his life—his dependent years where adequate mothering insures trust and security, the period when he "evolves" into a social being, the period of identification, and the turbulent period of adolescence—all bring frustrations as well as rewards. How the child will adjust will depend to a great extent upon the interaction with his parents and the strength they can transmit to him. For the white parent of a black child even greater strengths are needed, both because of the racial difference and the climate in which we live.

The need to belong is a basic human requirement. The white family that has adopted a black child has a grave responsibility to prepare the child to live in a social environment in which he may not always feel accepted. His anchor will be his feeling of trust, security, and of self-worth. On the road to maturity, his parents must provide opportunities for him to establish his identity through learning about and meeting other black people whom he can admire. They must also help him face reality. Part of the reality for any adopted child is the fact that he was not born into the family. For the black

child who has been adopted by white parents there is also the reality of racial difference. It must be understood and accepted, both by the parents and the child. "If we accept the premise that all people are special, we are better able to deal with the differences in different individuals."¹³

Black parents

While transracial adoption offers a means of providing families for some children, it can be only a small part of the answer for black and mixed black white children who are awaiting placement. Despite the growing interest in interracial adoption, not all prospective adoptive couples are capable of adopting children of another race.

Transracial adoption is, in fact, a controversial issue today. There are both white people and black people who reject the concept. In some, the rejection derives from racial prejudice, in others, from a feeling that white adoptive parents could not possibly understand a black child's world in a racist society.

Sometimes the adoptive parents' motives are misunderstood, and they are regarded as "sacrificing child" to promote the cause of integration. If the promotion of integration is the motive for a white black adoption, surely the child will be sacrificed for it is not enough. Some blacks say that a black family can build a mechanism in a black child by which he can cope with racism and survive, but that no white person can possibly accomplish this task.

Because of the nationwide shortage of applicants for black and mixed racial children, the Social Research Group of George Washington University and the Children's Bureau are carrying out a cooperative project to help agencies improve their recruitment techniques and reach prospective parents who have gone unnoticed. In each of five cities—Atlanta, Chicago, Los Angeles, New York, and Washington, D.C.—representatives of adoptive agencies, adoptive parents, and members of the black community are being interviewed for their suggestions of ways to increase the number of adoptive homes for black children. The results of these interviews will be analyzed and reported in a publication. Later, regional meetings will be held to assist interested agencies in developing methods to increase their reservoir of such homes.

While the survey has not been completed, early reports of the interviews give clues to special problems in finding homes for black children and also some suggestions for new approaches. An important

reaction of some respondents is that there are a sufficient number of black families who could become adoptive parents if greater efforts were made to find them and develop different approaches in reaching them.

This contention has been borne out by a project in Detroit called Homes for Black Children.¹⁴ Within a 9-month period of intensive recruitment, 100 black children were placed for adoption; of these, 99 were placed with families of their own race. Special techniques to reach the black community included personal appeals, assignment of black persons to discuss adoption with members of black organizations, and special canvassing efforts in predominantly black neighborhoods.

Some of the people interviewed in the cooperative Children's Bureau-George Washington University project have mentioned possible deterrents to applications for adoption from black families. These include the generally lower economic situation of black families as compared with white; the tendency among some black families to regard social agencies as a "white man's resource"; an impression that all adoption agencies require proof of sterility; a reluctance to be questioned about personal matters; expectation of rejection from having experienced it at every turn in life; anxiety about filling out required forms; and inability to meet legal fees. Some past studies have suggested that black families "in a position to adopt" are as interested in adopting as are white families.¹⁵

Some respondents in the current study have reported no objection to transracial placements; some have accepted the practice as a second-best plan only; others have rejected the concept altogether on the premise that cultural confusion will cause undue conflicts for the child, especially in relation to his identity.

Without a doubt, new methods of approaching black families must be developed if the approximately 40,000 black or mixed racial children who are waiting adoption are to have families of their own. Adoption agencies must be willing to reach out to black families every step of the way, to help the families understand what agencies need to know to fulfill their responsibility toward children, to let the families know that their warm human qualities are appreciated, to support them in every way through the adoption process, and to increase understanding in the agencies of the families' areas of resistance.

Many organizations have been formed around concern for the children who need adoption—Families for Interracial Adoption in Boston, Open Door Societies in Montreal and in many States in this country, the Council on Adoptable Children, with headquarters in Ann Arbor, Mich., Opportunity in Portland, Oreg., the National Council of Adoptive Parents Organizations, with headquarters in Teaneck, N.J. They are indispensable to adoption agencies for the part they play in recruitment, in urging flexible practices, and in supporting progressive legislation. However, except for the National Council of Adoptive Parents, their emphasis is largely on transracial placements. It might be well for them to consider all possible resources for black children and engage in recruitment efforts for black families as well.

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DAY CARE FOR CHILDREN

assets and liabilities

ELIZABETH PRESCOTT

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● Today many concerned people advocate group day care as an opportunity to get the preschool children of poor families out of what they regard as inadequate homes into educational settings. If his home *is* inadequate, a child may indeed need the experiences that a good home would provide. However, on the basis of our research, we question the assumption that group day care necessarily will provide all the experiences a child needs.

During the past 7 years we have interviewed mothers of children in day care and day-care teachers and directors and have observed programs in approximately 100 centers in Los Angeles.¹ In a recent study we intensively observed a random sample of 50 centers—some under public and some under private auspices—to analyze differences in daily programs offered to children.²

We found marked differences among the centers in the behavior of teachers and in their style of presenting activities. In some centers, teachers characteristically responded to individual children by supporting and encouraging spontaneous play; in managing social relationships, they emphasized consideration for the rights and feelings of others. In other centers, there were many more teacher-directed group activities and more emphasis on control.

We found that these differences in patterns of programs in day-care centers were associated with the attitudes and training of staff, the quality of physical space, and the center's size. Centers in which we

rated the teachers' manner as sensitive and the children's involvement in the activities as "high" were most often those that were of moderate size (30 to 60 children), that had good physical space as indicated by organization and amount to do per child and that were staffed by teachers with some special training in early education.

Although we found marked differences among day-care centers in the variety and quality of the experiences available to children, we concluded that even when quality is good, group day care tends to provide a set of experiences somewhat different from those provided in family homes. Behavior settings (in the present discussion, family homes and day-care centers) appear to possess inherent regulatory features that stem from the purposes for which the settings exist, their physical attributes, and the number and kinds of persons present in them. These aspects of a setting determine to a great extent the activities and types of behavior that will probably occur within its boundaries.³ When a setting is not optimal for certain kinds of activities and behavior, such actions are not likely to occur unless the adults involved are highly motivated to bring them about and are exceptionally skilled in doing so.

Environmental influences

The group day-care setting exerts a powerful regulatory force on activities and behavior, encouraging some that are not easily evoked in a family and eliminating others that occur easily at home. Group day care uses the nursery school, not the home, as its model. We see this model as different in significant ways from the model of a good home, and we suggest that a little nursery school goes a long way.

The half-day nursery school offers young children a protected environment scaled to their developmental level and designed to promote experiences of mastery within a child-sized, manageable world. Offered for a few hours a day, often for only 2 or 3 days a week, this experience is a balance to the child's home and community life, which takes place in an adult-sized, complex environment full of problems, emotions, and demands. Smooth programming in the nursery school may free children to explore a circumscribed environment and temporarily shield them from the need to cope with the larger world.

The temporary aspect is important. Nursery school introduces greater variety into the homebound child's daily routine. But nursery school has limitations as a learning environment as well as assets; it is designed

to supplement, not substitute for, the experiences provided by a good home. *The longer the day for children in group care, the more home as well as nursery school characteristics should be incorporated into the program.* To plan programs with this objective, it is necessary to have a clear picture of the characteristic differences between home care and group care. Unfortunately, little thought seems to have been given to these differences.

Both at home and in school, children need opportunities to solve real problems. Real problems for a young child include the need to learn—

1. How to cope with oneself—with one's body, with feelings, and with being alone.
2. How to cope with other children.
3. How to cope with adults—their expectations, rules, rewards, and punishments.
4. How to cope with the natural environment— dirt, rocks, animals, weather.
5. How to cope with the man-made environment— cars, furniture, toys, written language, and so forth.

In general, the man-made environment is more predictable and less infinitely complex than the natural environment, though this distinction may mean more to adults than to children. Learning tasks of all sorts, including traditional academic skills, fall into category 5 only if they are selected as problems by the learner. If the task is assigned by a teacher or other adult, the real problem for the child often is not the task itself, but his relationship with the adult.

How do good homes and group programs for children differ in the problems they present to children? One way to compare them is in relation to a series of dimensions, or kinds of experience, that have impli-

cations for the quality of children's growth. A child's total experience should provide some balance along each of these dimensions. Some experiences are more easily provided in family homes than in group care. Even in good full-day group care it is difficult to offer an appropriate balance. To do so, the day-care staff must know something about each child's home environment as well as about the potentials of the day-care center environment.

Freedom to grow

Several kinds of experiences may foster or restrict a child's sense of self. For example:

Expression of emotions—control of emotions. Our studies indicate that programs in day-care centers typically are marked by an absence of strong feelings and of activities that might evoke them. Many staff members appear to be afraid that open expression of strong desires, in the form of anger, dependency, or abandoned exuberance, would lead to behavioral contagion and chaos.

Family homes, in contrast to most other social settings, are places where expression of strong emotions is expected if not always approved. In a home with underlying affection, children learn that the loss of emotional control, either by adults or by children, need not be disastrous. However, the level of intensity of interpersonal relationships and inconsistency in adult behavior toward children may be greater in some homes than a small child can cope with.

Nurturance—independence. Group day care gives children less access to adult attention than they would have in a good family home. At a very early age a child is expected to get along with relatively little nurturance and personal attention, and to adapt to being cared for by a series of adults. In many day-care centers the physical expression of affection by teachers is discouraged; the feeling seems to be that if their laps were made available to the children, the teachers would be continually smothered.

Clearly, some families promote overdependence in young children. The mother whose primary satisfaction comes from her child's need for her may be reluctant to let him leave her side and do things for himself. Group day care can provide the child with a healthy chance for self-help. It also rather typically provides a more impersonal child-rearing environment, likely to reduce, rather than enhance,

Elizabeth Prescott (left), a psychologist, and Elizabeth Jones, a sociologist and specialist in early childhood education, have since 1964 been director and research associate, respectively, of a series of studies on day care sponsored by the Pacific Oaks College and Children's School in Pasadena, Calif., with support from the Children's Bureau. Previously Mrs. Prescott was with the Welfare Planning Council of Los Angeles. Dr. Jones, who has been with the college since 1954, is now director of graduate studies.



a child's sense of his own importance and to offer relatively few experiences to foster a sense of identity.

Individuality—group membership. A good home fosters a child's self-knowledge by providing almost unlimited access to an adult who will answer his questions of the moment and who will respond with warmth and concern to his attempts to comprehend the world and give it form through language. Perhaps a child's strongest impetus toward growth comes from his family's interest in his individual style of development, its encouragement of his new accomplishments, and its readiness to modify its activities and schedules to meet his particular needs. Under these circumstances it is clear to the child that he is important and that how he feels and what he does matters to others.

Even in the best of day-care centers, individual attention is more limited, and in centers of poor quality it is almost nonexistent unless attained through behavior that demands adult intervention. Perhaps the greatest liability in group day-care placement lies in the likelihood that neither the child's mother nor his teacher will be able to pay close attention to his individual way of developing and the unfolding of his personality.

Freedom—supervision. At home adults have many things to do. The child is often out of their sight;

These children in a day-care center are learning an adult role by helping to make a batch of cupcakes—a common experience for children who spend the day at home with mother.



consequently, he has opportunities both for privacy and for deciding whether to conform or to break rules. These opportunities to exercise initiative in deciding what to do and whether or not to live up to adult expectations for his behavior are valuable to the child in developing his sense of personal identity, his concept of who he is, and what he can do.

Concern for safety in group day care tends to restrict this type of freedom severely. Individual children are seldom permitted to remain indoors if the group is outside. We found in Los Angeles that most play yards are designed so that children cannot go off into secret crannies. During nap time cots are placed in an open room; for a child to be provided semiprivacy at nap time usually carries the connotation of misbehavior. Typically, children are not permitted to be out of an adult's view and consequently are also continually accessible to other children.

Relationships

In large families and in neighborhoods with many children, much of children's learning comes from each other. In the "open education" model of British infant schools, as in the traditional American one-room schoolhouse, a cross section of different age groups insures that children will teach children

Peers and others. American nursery schools, like the public schools that follow them, tend to be organized in age-graded classes. Again, a little nursery school goes a long way. To be a 4-year-old in a group of other 4-year-olds for 2 or 3 hours a day offers the child an excellent opportunity to test himself and to interact with others very much like him, without interference from older or younger children. To restrict his experiences to his peers all day long is to fail to provide the kinds of learning that can occur in other settings. In our studies we found wide age grouping of children in day-care centers associated with high interest and involvement on the part of the children and a sensitive manner in the teacher.

Day care offers children the opportunity to develop new relationships outside the family, with adults as well as children, and to gain confidence and skill in leaving parents and forming friendships. These relationships are likely to be more superficial than those within the family; they are usually smoother and the behavior of those involved toward one another more predictable.

At home, the child is able to observe his parent

daily activities in the home and neighborhood as well as in other community settings. Generally day-care centers offer children very few opportunities to observe adults in varied work roles. However, some day-care centers permit children to interact with visitors as well as with their own staff members who perform interesting tasks—cook, housekeeper, custodian—thereby enriching the child's learning environment.

Role models. Both boys and girls need adult role models of both sexes. In families, these models are provided by the presence of both parents or by close extended family relationships, or both. Although many of the children in day care do not have fathers living at home, very few nonprofit day-care centers we observed had men playing active parts in the program. However, in Los Angeles proprietary centers staffed by husband-wife teams are fairly common. Such centers can offer an effective opportunity for meeting the children's need for sex role models.

Activities

Day-care centers carefully schedule the children's day to provide a balance between activity and rest. Where this schedule is fixed, however, it may fail to coincide with the rhythm of individual children. For example, a child may be required to nap whether he needs to or not, without regard for the effect on his bedtime at home.

At home, the mother sets activities according to the child's individual need and the family's routine but the child is likely to determine a great deal more of his own activity schedule.

Choice—conformity. In most homes preschool children have few assigned tasks; they can choose what to do in between the daily routines as long as they refrain from attracting negative attention from adults. While some homes are overstimulating, others encourage inactivity, such as television-watching, for long periods of time. Some homes offer relatively few activity choices, either because space and materials are scarce or because many potential activities (water play in the sink, investigation of mother's bureau) are forbidden.

Day-care centers usually offer many potential activities, but vary widely in the extent to which choice of activities is made by the children or teachers. Children can learn obedience and gain security from assigned tasks; they probably gain a keener sense of

who they are in relation to the world by making their own choices.

Physical activities. Many urban homes offer very few opportunities for large muscle activity, such as climbing, running, or jumping. Because of space limitations, parents emphatically discourage such activity indoors and often cannot safely let young children play outside without an adult. There is usually greater opportunity for such activity in day-care centers, although in some centers limited space and teacher concern for group control may also discourage extensive free movements.

Small muscle competence is developed through table activities of all sorts. Such activities may or may not be plentiful in family homes. Day-care centers are usually rich in such activities, although in some programs they are overemphasized at the expense of large spontaneous movement.

Time schedules. Time schedules in homes where the mother does not work are usually flexible. They may become more complex and demanding if older children must be transported to school, if a father works nights and must sleep during the day, or if medical problems require long waits in clinics or doctors' offices.

Maternal employment, especially on a full-time basis, represents a crucial interference with flexibility in child rearing. The mother who must be at a place of employment within a set work schedule and must transport her child to a day-care center within this schedule, is likely to be constrained in her daily relations with her children by the urgency of household tasks, schedules to be met, and fatigue. Since the strains of such scheduling are likely to be experienced by all children in full-day group care, relaxed scheduling in day-care centers seems important for providing children with a balanced experience.

A principal disadvantage of large day-care centers lies in the necessity for coordinating the movement of many people. This results in inflexible scheduling and lack of responsiveness to children's individual needs.

Learning opportunities

Group day care generally offers good physical care, a routine, and a setting designed to be safe for young children. In a good day-care center the variety

of play materials and equipment—climbing apparatus, swings, sandbox, playhouse, art materials, books, games, and puzzles—is superior to that in most homes. The learning opportunities available to children in such settings are many, particularly when a skilled teacher helps children make full use of the environment.

Day-care centers, however, often fail to offer children opportunities to test the limits of skill. For preschool children, skills are usually physical. They quickly master the normal use of play equipment, such as tricycles, swings, and slides, and some think up variations of their own, but teachers often seem overly restrictive toward any attempt to use such equipment in unorthodox (and more challenging) ways.

One of the advantages of a family home is that it is not smoothly programed. It is primarily a place where the mother occupies herself with a continual meeting of immediate needs, many of them having little to do with children. In the course of this activity she provides a child-rearing environment that has a broad range of stimuli. Often the circumstances that are problems to her provide opportunities for children to see how the adult world operates and to learn that the unexpected can be handled. The water heater goes bad and brings a plumber to the house, groceries must be purchased to feed unexpected company—each of these events produces an input of novel stimuli.

In contrast, a smoothly running day-care center can quite easily insulate children from unplanned encounters; they may have no contact with the kitchen, the street, or anyone coming in the front door. This results in monotony for adults and children alike. Moreover, we found that only in a very few centers are children taken on excursions into the community; many do not permit children to go outside the premises even for a neighborhood walk. Some centers avoid such isolation, however, by the simple expedient of making use of unplanned events—for example, watching a repairman and talking about what he is doing—as well as by planning special excursions into the community.

Rural homes offer the child a rich natural environment. In cities, family homes and day-care centers alike may be hard put to offer experience with animals and an accessible natural environment. Covering a yard surface with asphalt for easy maintenance appears to be an irresistible temptation for

builders of day-care centers. Such yards are difficult to organize for optimum play use, and they fail to provide experience with the natural order of the world—trees, bushes, dirt, grass, and all their associated creatures.

Selecting a balance

Throughout this discussion, we have suggested that all children need a balance of experiences along each dimension. While in abstract developmental terms this may be the ideal, in the real world children are reared to live in particular societies and social groups. Consequently, the sort of balance to be provided along any of the dimensions mentioned here will vary with the values of the concerned adults and their assessment of the individual child's needs. This kind of assessment can only be made after a realistic appraisal of the experiences that the settings available can provide.

Obviously, working mothers need access to good day care for their children. Group care, however, is only one of several options. Other possibilities are family day care or half-day nursery school with afternoon care in a family setting. Little thought seems to have been given to the possibility of increasing the quality and availability of these important options.

Imaginative and careful planning by day-care staff seeking to find ways to provide some of the experiences that may be missing in group care can greatly enhance a day-care program.^{4,5} Administrators need to support staff innovations that enrich children's experience even though uniformity and predictability may be reduced.⁶ Finally, good parent-staff communication can often provide a balance in opportunities for growth even in the most promising settings.

¹ Prescott, Elizabeth: A pilot study of day care centers and their clientele. U.S. Department of Health, Education, and Welfare, Children's Bureau. Publication No. 428. Washington, D.C. 1965.

² Prescott, Elizabeth; Jones, Elizabeth: Group day care as a child-rearing environment. Pacific Oaks College, Pasadena, Calif. 1967.

³ Barker, Roger G.: On the nature of the environment. *Journal of Social Issues*, October 1963.

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GROUP SERVICES FOR UNMARRIED MOTHERS

an interdisciplinary approach

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For the past 2 years a public health nurse and two social workers in Anoka County, Minn., have been working together in a group program to help unmarried mothers prepare for delivery and plan for the care of their babies. The program, which got underway in May 1969, consists of a series of prenatal classes designed to meet the physical and emotional needs of the expectant mother. It includes the provision of information about pregnancy, labor, and delivery; the opportunity to consider alternative future plans; and the support of other girls in a similar situation. It involves the close working together of the county health and welfare departments as well as the two professions.

The idea for the program originated with a public health nurse in the county health department whose responsibilities included making post partum visits to unmarried mothers. She noted a repeated pattern of difficulties among her clients: physical discomforts and complications during pregnancy, anxiety and fear regarding bodily changes and changes in their life styles and relations with other people, and generally difficult labor and delivery. She saw clearly the need of unmarried pregnant women and girls for a program of prenatal information, support, and assurance.

Her interest led the nurse to contact two social workers in the Anoka County social service (formerly the Anoka County welfare department) who were also providing services to unmarried mothers. The three workers agreed to cooperate in developing a program using the combined resources of their departments to improve services for unmarried pregnant girls in a suburban area near Minneapolis.

Because most unmarried pregnant girls seem to believe that the only person who can understand them is another girl in the same situation, the three workers decided to explore the possibility of conducting group discussions. They asked several pregnant teenagers if they would be willing to participate in a group to discuss their problems. The girls said they would welcome an opportunity to talk with other girls who were having similar problems about the reaction to their pregnancy of their families, the unborn babies' fathers, and other people in the community and about plans for themselves and their babies. Girls who had already resolved some of their conflicts said they felt they could contribute to, as well as benefit from, a group discussion.

The next step was to obtain approval of the plan by those community representatives who might become involved as sources of referral or who would be concerned about the quality of the medical informa-

tion to be imparted. Private physicians and staff members of schools and hospital clinics in a position to know girls needing the services promised their support. Members of the obstetrical staffs of the hospitals in the county also gave their approval, along with helpful suggestions for prenatal instruction. One of the hospitals agreed to provide a meeting room for the program at no cost to the county.

Program plans

Planning for the structure of the program resulted in a decision to hold 2-hour meetings one evening a week for 6 consecutive weeks, with the nurse and one social worker serving as leaders. After two groups had completed the program, the other social worker became a discussion leader.

The first hour of each session would cover physical and related emotional characteristics of pregnancy, following the general format of existing prenatal programs conducted by hospital staff members for expectant parents. Topics would range from human reproduction to nutrition to family planning.

The second hour would consist of group discussions of common social problems facing unmarried pregnant girls, with the topics ranging from the attitudes of others in their age group toward pregnancy to future plans for the mother and her baby. It was decided to focus attention on specific topics each evening in the interest of making the discussions more relevant, the sessions more productive, and the girls less anxious.

A letter explaining the program, an outline of the topics for each session, and an invitation to pregnant girls in and out of school to attend the sessions were sent to counselors and school nurses in the high schools, the technical education center, and the junior college located in the county. One school district encouraged participation in the program by giving unmarried mothers academic credit for attending the classes. The letter was also sent to medical clinics and hospitals with obstetric clinics.

When an unmarried mother was referred to the program by the public agencies, the public health nurse or one of the social workers personally interviewed her to explain the program. Girls referred from other sources were also contacted, and if they expressed interest, they were mailed a letter, an outline, and an invitation to the class. Since the girls knew the subject of each session before entering the program, they were able to decide whether they wanted to commit themselves to attending. A few

days before the first session, the group leader telephoned prospective participants to confirm their interest in the group meetings. For girls without transportation, arrangements for rides were suggested.

A total of 51 girls participated in the five group programs held between May 2, 1969, and January 1971. They have come from both low- and middle-income families. About 70 percent of the referrals have been made by staff members of the Anok County social service, while the rest have come from schools and hospitals with obstetric clinics.

These statistics do not reflect the cooperation that the program has received from many agencies that work with unmarried mothers. Although a participant may have been referred by only one source, staff members of other agencies that served her also actively stimulated the girl's interest in attending classes.

Participants in the groups have ranged in age from 15 to 30 years, with a mean of 19 years. The average educational grade level is 11.5, with a variation from ninth grade to 4 years of college. Although the largest group (43 percent) is students, the girls' occupations also include secretary, factory worker, and waitress. Ninety-two percent of the girls are experiencing their first pregnancy; 57 percent live with their parents at the time they enter the program.

The largest group included 16 girls, the smallest eight. For the five groups, attendance per session averaged 74 percent of the girls enrolled.

The professional roles

The public health nurse's primary responsibility is to provide prenatal instruction during the first hour of each class. This involves making arrangements for the physical setting, equipment, material, guest speakers, and other resource persons. In addition, the nurse prepares detailed, written material for each session, based on current medical information.

The nurse's goal is to increase the unmarried mothers' knowledge and understanding of all aspects of pregnancy, labor, delivery, and post partum. She believes that factual information will help the girls overcome some of their misconceptions and reduce their anxieties, and so enable them to accept pregnancy and prepare themselves for the course ahead. Therefore, the nurse not only informs, explains, demonstrates, and clarifies, but also encourages questions and expressions of concern.

During the group discussion of social problems, the social worker serves as leader. The nurse complements the social worker's efforts by pursuing the girls' responses in depth and eliciting clarification when needed. She also observes the girls' nonverbal responses and encourages them to express their reactions to what the group members say. By providing an opportunity for all members to participate, the nurse thus expands group involvement.

The social worker's goal during the second hour is to help the girls explore common social concerns and prepare for the decisions they will make in dealing with problems surrounding their pregnancy. She presents such topics for discussion as reactions of the girl's own family and her changing relations with the father of her unborn child. By asking questions, the social worker gives each girl a chance to express her concerns about the topic; by drawing out other members, she broadens their perspectives. The differing opinions expressed present alternate ways of looking at the problems. Sometimes the social worker reminds the members of their comments from previous sessions to expand the discussion and increase group involvement.

The social worker also uses the discussion to help group members clarify their concerns about pregnancy and motherhood and be more explicit about their feelings and relationships. For example, she has found that often girls are hesitant about deciding whether to place their unborn babies for adoption. When other members of the group express concern about keeping their babies, the leader notes the similarities and points out that although each situation is unique, the girls share common feelings. As the girls explore these feelings, they become more honest with themselves, more realistic in coping with their problems, and better able to make sound decisions.

The social worker also attends the hour of prenatal instruction and briefly answers questions about non-medical aspects of pregnancy. If the subject is relevant or of widespread interest, the group discusses it during the second hour of the program.

Realizing the importance of their roles as group leaders, the nurse and the social worker conduct continuing self-evaluation in relation to their interaction with the group. With the girls' permission, they also make a tape recording of each discussion session. Using these tapes and their individual impressions, the two leaders periodically evaluate their group work skills and the dynamics of each session. The coordinator of the county's mental health program,

an experienced group worker, meets with them to provide consultation.

As an objective third party, the mental health coordinator is able to assist the two leaders in clarifying the complementary nature of their roles in the program. He has helped them resolve a problem common when two professionals working with the same client fail to recognize that they are providing overlapping services, have possessive attitudes, and distrust each other's qualifications for meeting the client's needs.

Initially, the social worker had reservations about the nurse's role in the second hour, believing that the nurse's involvement in the discussion of social problems would be an infringement on her own area of expertise. Through a frank talk with the nurse, the social worker became aware of the overlapping emotional aspects in social and physical problems of an unmarried pregnant woman. The representatives of the two disciplines were then able to agree on their respective roles and work together effectively in the group discussion period. The experience with the group further helped the social worker see the value of the nurse's contribution to the discussion of social problems of the girls.

Content of the classes

As the program now operates, a detailed schedule is announced for the entire 6 weeks at the beginning of each series of classes. The leaders explain the purpose and goals of the program and ask the girls to discuss their expectations for the classes. The confidentiality of the information is stressed. The girls are encouraged to express any dissatisfactions with the format of the classes and suggest topics they would like added. Attendance at every class, or even both hours of a class, is not required.

Session I. Although the sequence of topics for the first hour is similar to the format generally used in prenatal classes, the hour on relaxation in preparation for labor is offered early in the series because the majority of the girls are in their third trimester of pregnancy when the class begins. A class on breast feeding is replaced with one on family planning.

The first half of the first session deals with human reproduction with emphasis on the normal physical and emotional changes that take place during pregnancy and danger signals that need to be brought to the attention of a physician. Because some of the girls have little or no knowledge of the process, the

film "Human Reproduction" is shown. During the group discussion that follows the film, misconceptions are cleared up. The nurse then offers to make a home visit to any girl who wishes to discuss the subject individually. The nurse's technique for teaching about normal developments that occur during pregnancy is to ask the girls to identify the changes they are experiencing. Including the girls as participants in the information-giving process stimulates questions and prompts some of them to talk about their individual concerns and experiences with the group. Pamphlets on prenatal care, human reproduction, and fetal development are distributed to the girls.

The second half of the first session looks at the participants' community and peer relationships and their own reactions to the pregnancy. The girls have reported reactions ranging from feeling happy, to considering abortion, to completely denying the pregnancy. Little interaction between the group members takes place at the first meeting because they are not ready to risk the disclosure of their deep emotions without knowing more about each other.

The first group of girls was shown "Phoebe," a film about the reactions of a girl who had just discovered she is pregnant. The group members, most of whom were dealing with problems of the seventh and eighth months of pregnancy, did not find the film helpful since that phase of pregnancy was far behind them. On their recommendation the film was not shown to later classes.

Session II. The first hour of the second class, which presents exercises to prepare the girls for labor and delivery, is one of the most important prenatal sessions. Anxiety about labor and delivery, combined with feelings of aloneness and fear of what is to come, often predisposes unmarried girls to fight labor. To help the girls overcome such anxiety, techniques and exercises that are proven aids in labor and delivery are taught. The booklet, "Preparations for Labor: Breathing and Relaxation Techniques," is used as a guide for the class. A film is shown to demonstrate some approved breathing and relaxation techniques. Then the girls practice abdominal breathing and other exercises and discuss their benefits. The nurse encourages daily practice of these exercises and emphasizes their importance at each successive class by providing for a short period of practice breathing.

The second hour deals with the girls' relations with members of their own families. The goal of

this session is to help the girls recognize their families' influence on their pregnancy, planning, and decision-making. Out-of-wedlock pregnancy affects family relationships in different ways. Sometimes a girl develops a closer relationship and improved communication with her parents because of the necessity of dealing with the pregnancy. In other girls pregnancy seems to alienate them from their families. Often the girls have difficulty talking with their fathers about their pregnancy; since they are uncertain about his reactions, some do not discuss it with him at all.

In most classes the girls agree that they, not their parents, have been responsible for the pregnancy. However, most of the girls have said they had not received adequate sex education either from their parents or from school. They seem to feel that the emotional factors involved in boy-girl relations are just as important as the physical factors. Several girls have said if they had known more about these factors, their relationship with boys might have been different.

Session III. For the third session, a nutritionist from the county's agricultural extension service is invited to talk to the group. Unmarried pregnant women, particularly teenagers, have many nutritional problems. Their increased anxiety and emotional concern often cause compulsive eating, which generally means an increase in snack foods high in calories and low in nutrients. Therefore, weight control is a common problem for such girls. Another problem more common among unwed teenage girls than among pregnant women in general is toxemia of pregnancy. Emphasizing daily nutritional needs, the nutritionist points out that dietary requirements during pregnancy do not differ much from a normal well-balanced diet. She further emphasizes the need for increased iron during pregnancy to prevent fatigue and possible complications of labor. She challenges the girls to think in terms of high-quality well-planned meals during and after pregnancy.

The second hour focuses attention on the relationship with the father of the child. Girls often are deeply angry because the father of the expected child has deserted them or has shown no concern. If a girl still has contact with the father, she tends to protect him, offering excuses to explain why he has not accepted his responsibility. "He doesn't have a job but he is looking."

Discussions of conception usually remain superficial because the girls hesitate to talk about the

involvement in a sexual relationship. Although most of the girls recognize that it takes two to produce pregnancy and that the girl suffers the consequences of community disapproval if a child is born out of wedlock, they seem to feel that the man is the one responsible for providing contraceptives. They prefer to see themselves as having been romantically involved and taken advantage of by the boy. Therefore, the mental health coordinator comes to the group to discuss sexuality and boy-girl relations from a male's viewpoint. Some girls are able to look more closely at how they became involved in the relationship after this discussion.

Session IV. In each group, interest has reached its peak with the fourth session, which deals with labor and delivery and plans for the baby. The girls always express a great deal of anticipation of this class, possibly because they know least about this area, which involves their greatest fears and anxieties.

The nurse presents a chart depicting the process of birth—what takes place in the three stages of labor—and outlines the roles of the mother, the nurses, and the doctor during each stage. The nurse explains ways of distinguishing between true and false labor, discusses signs of possible complications, describes special obstetrical procedures, and introduces the vocabulary that is used in the hospital.

The high point of the class is usually a film depicting a normal birth. This film showing is followed by questions and discussion. For most of the girls the film allays fears by substituting concrete information about the birth process for old wives' tales.

In the discussion hour the girls talk about bringing up a child without the support of a father, arranging for child care, and the importance of a child having a father. The goal for this discussion is to help the mothers make a sound decision after thoroughly weighing the pros and cons of keeping or placing the baby. The girls usually question their own motives—Is it selfish to want to keep the infant or to want to place him? If the girl is still seeing the baby's father, the social worker suggests that she consider his influence on her now and in the future.

By the fourth session, most of the girls are comfortable enough in the group to challenge as well as support each other. When a girl has not really thought through her decision, group members periodically challenge her by suggesting some of the problems she is likely to encounter. However, there

are always a few girls in each group who do not become secure enough to risk questioning the plans of others.

Session V. The fifth meeting begins with a tour of the hospital's obstetrical floor, including post partum, nursery, labor, delivery, and recovery areas. Several girls have reported that they "feel better" after seeing a delivery room and hearing an explanation of how the equipment is used.

After the tour, the girls discuss post partum care. The nurse describes normal body changes, emphasizing the need for a gradual increase of activity to a normal level. Because these girls tend to be eager to regain their figures, she warns them against over-exercising. She also tells about the emotional adjustments that mothers often have to make after the birth of a baby so that the girls will realize ambivalent feelings and "blues" are not unusual.

The session continues with a discussion of infant care. The nurse outlines procedures and responsibilities involved so that the girls' ideas about a baby's needs will be realistic. Booklets on child care, growth, and development are distributed.

The discussion period is focused on adjustments the girl might make after her baby's birth. The group members examine employment, education, their living arrangements, and problems they might encounter in dating and social life after their period of relative isolation during pregnancy. The girl who plans to keep her baby considers arrangements for babysitters, involvement of her own parents in their lives, and the effect the child will have on marriage. Many of these girls have said they will consider marriage only to a man who accepts the child completely. Those who plan to place their baby for adoption usually say they will tell their future husbands about the child before marriage.

At this point of discussion the social worker introduces two unmarried mothers—one who has kept her child and one who has placed her child for adop-

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tion. Both tell of their experiences, and the group members ask questions. The girls seem to feel that they gain a more balanced perspective toward their future from learning about the adjustments these mothers have made. The social worker has noticed that girls tend to pay most attention to the unmarried mother whose decision was the one they favor. In some cases, the girls distort or misunderstand the words of the mother with whose viewpoint they disagree.

Session VI. For the final class, which is on family planning, a public health nurse from Planned Parenthood talks to the group. She presents family planning information as information all women should have that may be of interest to the girls in the future. She discusses the principal methods of birth control and shows a diaphragm, a condom, foam, intrauterine devices, and the pill. Misconceptions are cleared up about the effectiveness of such methods as douching, withdrawal, and polyethylene wrap in preventing pregnancy. The discussion is not directed to any specific girl and is therefore nonthreatening. The girls always ask questions freely in this session.

The last meeting also includes oral and written evaluations by group members. The girls usually say the sessions are helpful in meeting their problems. Many have pointed out that they have gained confidence in themselves by learning of other girls' problems and realizing they are not alone. Among their comments: "I'm not as bad as I thought I was," "Now I don't have any more nightmares," "I was depressed when I came to the first meeting. Now I can laugh."

Assessment

In their written and oral evaluations, the unwed mothers have cited as the program's most significant benefit for them an increased understanding of physical and social aspects of pregnancy. Both the nurse and the social worker believe the groups have not only met their original goals but have provided additional benefits for those attending.

Most girls have remarked that they developed a more positive attitude about pregnancy. Many have added that group discussions have enabled them to think through their own problems more effectively and reach a clearer perspective. Such comments as

"I felt more relaxed knowing there are others with more problems than I," indicate that the girls have developed a broader viewpoint through the experience. For many girls, the sharing of problems in a group with others in their same situation leads to new friendships.

Group cohesiveness has been shown by a number of requests from each class for a followup meeting to compare experiences, current situations, and plans for the future. Each group has held one such reunion 2 to 3 months after its final session. Generally, the girls have reported that their anxiety during labor and delivery has been reduced because of their increased understanding of pregnancy and the preparation for delivery that they received.

From an agency viewpoint, the program has proved beneficial on both an administrative and service basis. The social worker and nurse have learned more about each girl through her contributions to the class discussion, and the girls in turn have become more open with the workers outside the class. When asking for individual service from an agency the girls who have been in the program are aware of the available resources and are willing to discuss the problems on which they want help. Improved communication between the professional workers and the girls gives evidence of the trust that has developed through the group experience. Thus, both the nurse and the social worker, by reducing individual home visits, are able to spend their time more effectively. As the program has continued and the community has become more aware of the service available, referrals to the classes of unmarried pregnant girls from schools, hospitals, and clinics have increased.

A significant factor that has contributed to the success of the program is the cooperative effort of the two agencies. Professional workers from the various disciplines are able to direct their effort toward presenting a comprehensive program for unmarried mothers. By combining resources and individual abilities, the workers resolve professional differences with the recognition of the similarities and unique qualities of each. From this experience of cooperative team effort, communication between the two agencies has improved considerably, and the total needs of the girls involved have been more nearly met.

THE USE OF DEVELOPMENTAL PLANS FOR

MENTALLY RETARDED CHILDREN IN FOSTER FAMILY CARE

In a recent experiment in California the foster mothers of children placed in family care from a State hospital for the mentally retarded were provided with individualized developmental plans with specific time-related objectives. Followup reports one year later on these children and their foster mothers (in this program called family caretakers") show that with one exception the children had progressed more rapidly than other children placed in family care from the hospital, and that their foster mothers' interest and pride in being special family caretakers had increased.

The experiment involved 27 mentally retarded children" ranging in age from 6 months to 20 years who were placed in family care by the Vallejo office of the State Department of Social Welfare, Community Service Division (CSD), from the Sonoma State Hospital. Developmental plans were constructed for 15 of these children and were applied to their family caretakers. The other 12 children were placed in family care without developmental plans. Twelve family caretakers were involved—six provided with developmental plans for the children in their care and six with no developmental plans.

The Family Care Program is operated by CSD for Sonoma State Hospital patients who have received all the help the hospital can give them, who do not need hospitalization but cannot return to their own homes, or who are not prepared for independent living in the community. The program's basic purpose is to help mentally retarded children and adults develop self-confidence and an ability to live as independently as possible. A team of professional persons from CSD and the hospital selects patients judged to be capable of benefiting from community living and places them with couples who have agreed

to open their homes to mentally retarded children.

In the past, family care placement preparations too often neglected those persons who had been, or would soon be, most closely involved with the patient—the hospital ward workers and the family caretakers. The idea of constructing individual developmental plans for the children to be placed in family care arose as a possible means of increasing the family caretaker's interest in the patient's progress. The hospital ward workers were also drawn into the project to work with the social worker, the family caretakers, and, in some instances, the children's parents in designing the developmental plans.

Each developmental plan was designed to provide the family caretaker with concrete objectives on which to focus as she became acquainted with the child in her care, guidelines for dealing with expected problems, and measures for evaluating the child's progress. The involvement of hospital ward staff in the construction of the plan gave the family caretaker an opportunity to learn important facts about the patient's behavior often excluded as "details" from the summary prepared for a placement referral.

General guidelines established for constructing the developmental plan suggested the inclusion of short-range as well as long-range objectives. Short-range, easily attainable objectives were recommended so that the caretakers might gain the sense of accomplishment needed to sustain their efforts toward realizing more difficult, long-range goals.

The guidelines suggested that parents who had kept up with their child in the hospital be invited by the placement worker to review the tentative developmental plan before its completion and prior to the child's placement. This process was recommended not only to mitigate some of the parents' feelings

of guilt over having their child placed away from home, but also to change the parents' concern from "what kind of place do I want my child to be in?" to "what is best for my child?" Thus, the focus in selecting a particular family care home for a particular child could be kept on how the child's needs could best be met.

All objectives in all developmental plans were to be stated in simple language that could be easily understood by the family caretaker and therefore readily applied. Requirements were set up for monthly discussions to be held between the placement worker and the family caretaker on the appropriateness of the plan and the child's progress under it and for written evaluations to be made at 6-month intervals. A sample developmental plan will be found in column 2.

Procedures

The experiment was based on the hypothesis that involving the family caretaker as part of a therapeutic team working to provide optimal opportunities for the patient would increase her interest in the Family Care Program as a whole, and that this increased interest would result in more rapid improvement in the patient and in a lower incidence of patient returns to the hospital. Another hypothesis was that the regular conferences between the family caretaker and the CSD social worker who had arranged the placement concerning the specific expectations in the developmental plan would increase the family caretaker's confidence in her ability to help the child as her accomplishments in relation to concrete objectives were recognized.

Every month each of the family caretakers involved in the project alternately filled out one of two forms: a patient evaluation form and an interpersonal checklist on her own behavior. Thus, six forms were turned in for each patient and family caretaker during the course of this experiment. Because it was impossible to place all the children at the same time, the period required to complete the experiment covered more than a year—from January 1968 through September 1969.

The patient evaluation scale included 10 aspects of the patient's status: health, verbal ability, moods, creative ability, peer group relationships, reaction to supervision, personal habits, attitude, progress, and prognosis. The family caretaker was asked to evaluate each of these aspects by selecting one of five coded statements, which ranged in tone from

SAMPLE DEVELOPMENTAL PLAN

James Jones

1. Teach James to tie his shoes.
2. Help James with his speech: teach him to speak more clearly and, if possible, in more complete sentences.
3. Help James with the development of motor controls—for example, coordinating hand and muscle movements in eating and in using scissors.
4. James has been a bit spoiled on the ward; help him adjust to the family care home by using a firm, but warm, approach.
5. Help James develop academic skills through participation in EMR program [classroom instruction for the educable mentally retarded] and some home instruction.
6. Work with James on his interpersonal relationships by involving him in activities and social events.

To The Caretaker, Mrs. Smith:

The above list includes a number of areas in regard to which the parents, social workers, and I feel James needs your help. The Community Services Division will be helping you to investigate the possibilities of enrolling James in the school program and helping him grow.

Please feel free to ask any questions you may have about James and request any help or information which you may need to achieve these planned objectives.

MR Placement Coordinator

optimistic and positive to pessimistic and negative. The third statement of the five was neutral in tone. Values of 5 through 1 were assigned to the statements, with 5 representing highly positive and decidedly negative. A value of 3 was given to the neutral category.

The interpersonal checklist developed by Timoteus Leary¹ was employed to obtain an assessment of the family caretaker's self-image. It consists of 128 descriptive words or short phrases that are representative of 16 basic personality characteristics: aggressive, blunt, exploitive, competitive, managerial, autocratic, responsible, overgenerous, cooperative, overcongenial, docile, dependent, modest, self-effacing, skeptical, and distrustful. For example, some of the words and phrases associated with "aggressive" were "good leader," "likes responsibility," "forceful," and "bossy." The family caretaker was

structed to check the words or phrases that she regarded as best describing her feelings about herself at that point in time.

The interpersonal personality system from which the checklist was taken covers five "personality traits." In this experiment, we were primarily interested in level II: "*conscious description*"—the caretaker's self image as determined by the verbal content of all the statements that she made about her behavior toward the child in her care and the relationship of this image to the patient's progress. The data from these checklists were later converted to standard scores for "love" and "dominance" under a system devised by Leary.²

At the end of the experiment the average scores of patients' progress and on family caretakers' love and dominance were compared between the two groups—the family caretakers who had used developmental plans and those who had no developmental plans. No definite conclusions can be drawn from such a small sample, but the results are in some ways suggestive.

Time changes

On the whole, the family caretakers who used developmental plans achieved higher love scores and lower dominance scores as the year progressed, while the opposite was true of the group that cared for children without the developmental plans. (See chart, page 68.)

Four months after the experiment began, family caretakers with developmental plans scored an average of 77.1 on the love scale and 88.8 on the dominance scale. At the end of the year these scores had changed to 86.6 on the love scale and 71.5 on the dominance scale. This suggests a definite increase in tendencies associated with love and a decrease in tendencies associated with dominance.

All of the family caretakers in this study participated in an 8-week training program offered by the Vallejo office of the community services division. It is apparent then that while patients were seeking a more open, warm, free experience, the family caretakers saw themselves as necessarily and desirably controlling figures.³ Our findings suggest that the use of a developmental plan combined with regular supervision from a social worker might have lessened the tendencies to dominate and afforded the patient a warmer, freer experience.

The findings also showed that individual patients for whom developmental plans were employed tended

to make more progress than those in homes not using the plan, but the differences between the groups were too small to be significant.

In the group in which developmental plans were employed, one child consistently scored so low that the overall score of the group was significantly lowered. Nevertheless, this child's family caretaker did not consider returning the child to the hospital. In the group without developmental plans, three patients out of the 12 were returned to the hospital before the year was up, while from the group with plans, only one patient out of 15 was returned to the hospital.

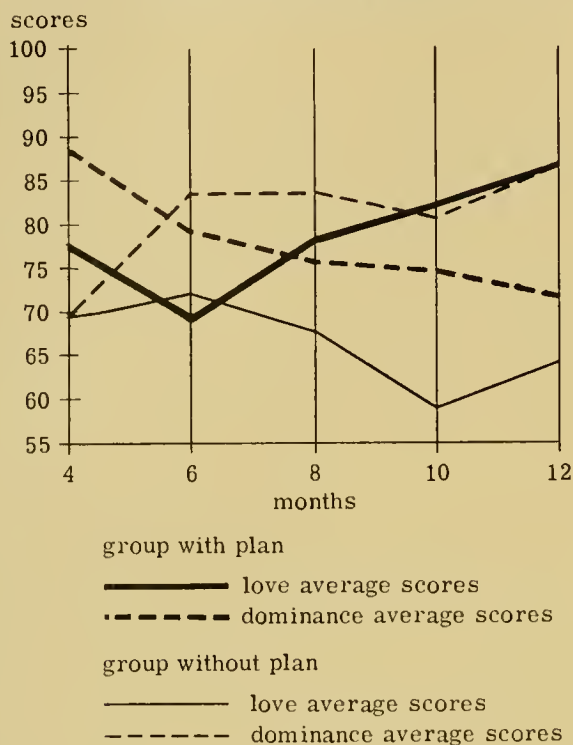
It might, therefore, be conjectured that providing the family caretaker with a developmental plan and regular supervision from a social worker increased the probability that the family caretaker would attempt to resolve problems when they arose rather than seeking to have the child rehospitalized. Perhaps these family caretakers were encouraged by receiving recognition for small achievements from their social workers in the periodic reviews of the child's progress toward specific short-range goals. The use of supervision to help the caretaker direct her care toward specific goals rather than to discuss the altruistic intentions of the Family Care Program undoubtedly enabled both the social worker and the family caretaker to keep their attention focused on the patient's needs.

It seems improbable that the use of developmental plans effected any significant change in the self-image of the family caretakers. It is likely, however, that the periodic discussions of the plans' objectives may have made the family caretakers feel more competent in their role and more like professional persons than mere custodians. An increased sense of competence may have been the reason the group employing developmental plans returned fewer children to the hospital than the group without plans.

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FAMILY CARETAKERS LOVE AND DOMINANCE AVERAGE SCORES



We had some evidence from this experiment that parents who participated in constructing or reviewing their child's developmental plan lost some of their guilty feelings about letting another family care for their child. Being allowed to play a responsible role in planning for their child seemed to reduce their sense of failure. For example, parents who did not review the developmental plans with the social worker before placement were constantly making inappropriate requests and inquiries of their children's family caretakers. On the other hand, parents who had participated in the construction or review of their child's developmental plan frequently contacted the social worker to ask if there were anything they could do to help achieve its objectives.

Problems and conclusions

The use of developmental plans was not without problems. Foremost among these was the burden on staff time. The CSD social workers involved had to

spend a great deal of time constructing developmental plans and in other preplacement preparation making the monthly visits, and writing the many reports the experiment required. Such time-consuming requirements tended to dampen their original enthusiasm for the plan. Another problem was the lack of any objective measurement of the effect of the experiment on the family caretakers. The conclusions presented here were largely based on rudimentary observation and assumptions. A larger sample of subjects with matched controls and a more refined research design is needed to test the validity of this experience with "a new thing" in the foster family care of mentally retarded children.

Because of a recent emphasis in California on populating State hospitals for the mentally retarded, additional efforts to further refine the use of developmental plans with family caretakers have not been undertaken. The family caretakers involved in the experiment, however, continue to use the original developmental plans, although after the conclusion of the experimental phase, further 6-month evaluation periods were discontinued.

This experiment certainly did not prove that providing developmental plans to family caretakers of mentally retarded children changes the self-image of the family caretaker or appreciably accelerates the child's progress. However, it did suggest that the use of developmental plans tends to counteract the family caretaker's inclination to control the child in a domineering manner and that it provides the family caretaker with a way of participating in efforts to help the patient achieve specific developmental goals as rapidly as possible. More important, perhaps, the construction and use of developmental plans for mentally retarded children placed in family care forced social workers, nurses, hospital ward workers, and family caretakers to think in terms of the child and his needs and to work together toward helping him reach his developmental potential.

¹ Leary, Timothy: Multi-level measurement of interpersonal behavior: a manual for the use of the interpersonal system of personality. Psychological Consultation Service, Berkeley, Calif. 1956.

² Leary, T. F.; Coffey, H. S.: Interpersonal diagnosis: some problems of methodology and validation. *Journal of Abnormal and Social Psychology*, January 1955.

³ Mamula, Richard A.: Developing a training program for family caretakers. *Mental Retardation*, April 1970.

USING SENSITIVITY TRAINING WITH JUNIOR HIGH SCHOOL STUDENTS

URI RUEVENI

Today many schools are seeking new ways to modify the classroom behavior of disruptive students. One such effort, to be described here, involved the use of "sensitivity training" by the formation of a "T-group" of 15 aggressive junior high school students whose behavior has been characterized by destructiveness, truancy, and fighting. The experiment took place during the last 5 months of the 1969-70 school term in an innercity junior high school in Philadelphia, Pa., attended primarily by blacks and Puerto Ricans. Its success led to the formation of a similar group this school year.

The program was developed in response to a request from the junior high school's unity team, a team-making body composed of counselors, teachers, vice principal, and parents. Located in a heavily populated black neighborhood, the school has about 400 students—95 percent of whom are black and the remainder Puerto Rican. The unity team approached the author early in the 1969-70 school year, seeking a consultant to organize and conduct an in-school program for students who were manifesting behavioral problems.

As a school consultant, I—a white male psychologist—decided to work with the unity team in devising a program. After several meetings we agreed to establish a sensitivity training group for students in whom teachers had been unable to cope. A counselor at the school—a black woman—was named leader.

From the beginning we attempted to make the program known to the entire school faculty. In addition to describing the proposed program and its purpose

at a faculty meeting, we sent a letter about it to each teacher.

The teachers were asked to submit names of students who would be likely candidates for such a program. Thirty names were submitted. The coleader and another school counselor contacted each of the students whose names were suggested. After a discussion of the purpose and goals of the group, the student was asked if he wished to join the group, and it was made clear that participation would be a voluntary choice on his part. Twenty students accepted, but five dropped out during the first 2 weeks.

The continuing group included 10 black and five Puerto Rican students from 13 to 15 years of age—eight boys and seven girls. It met for 2 hours once a week for 5 months, closing only at the end of the school year.

Rationale and objectives

Sensitivity training may be defined as learning to develop an increased awareness of the nature of one's own feelings and behavior based on experience in a group situation. The basic data for such learning are generated by the group members themselves, from their past experiences and from their current interaction with other members of the group.

Sensitivity training methods have been used therapeutically in a variety of settings—for example, residential institutions, psychiatric clinics, and hospitals.¹⁻⁵ In a recent study, Pollack used sensitivity training as an approach to group therapy with 8- to 10-year-old students; he found that teachers and

counselors reported noticeable improvement in the behavior of such students.⁶ My own work with adult schizophrenic patients has suggested that the techniques of sensitivity training enhance conditions that foster group support and trust for a troubled person and his family.⁷

The program in the Philadelphia junior high school was initiated primarily to find out whether 13-, 14-, and 15-year-old students who acted out their problems through disruptive behavior would be able to create some common bonds, share mutual concerns, begin to understand the nature of their own behavior, and explore their relationships with other students, their teachers, and parents. We were not so much interested in analyzing each child's behavioral problems as in developing his ability to communicate and to manage his feelings in the here and now.

Our objectives were to help the students increase (1) their *social sensitivity* (perceptions of and feelings about the personalities and emotions of other children, teachers, school personnel), and (2) their *behavioral flexibility* (ability to act appropriately in situations of an interpersonal nature that they encounter daily in and out of school). We believed that through the group process of interaction and sharing of experiences, the students would learn to modify some of their earlier behavior patterns and seek new approaches or alternatives in situations that require interpersonal skills.

Procedures

During the sessions we used a variety of group techniques and exercises to enhance the group process and realize our objectives. The following are some of the exercises that we introduced:

1. **The grab bag.** A paper bag filled with slips of paper is passed around the group. Each slip contains a familiar word, such as school, teachers, counselor, anger, fight, hate, and cool. Each group member picks one slip of paper, reads the word on it, and describes his feelings about the word to the rest of the group.

This gamelike exercise was beneficial because it encouraged many of the teenagers for the first time to express in words their feelings about their own behavior and their concerns within the school setting. We had selected words that we thought would evoke the emotions of these students. Initially, the student responses were negative. Their reactions to the word *school* were "boring," "I don't like it"; to the word *counselor*, "we can never see her," "too busy"; to the

word *fight*, "I like it"; to the word *teachers*, "they don't understand." At this time, we leaders merely listened, recognizing the students' feelings of disappointment and frustration, but refusing to take sides or lecture. We encouraged the students to express deeper feelings about these words. As the program progressed, the students changed their concepts significantly. Teachers became more "friendly." School became "a good place to know friends" or a place where "we can really learn if teachers will listen to us." Several students made a more positive association with the word *fight*—"we don't have to fight

2. **Strength bombardment.** One teenager is "it" and sits in the center of the circle. Each group member in turn describes what he likes about the one who is "it," and expresses all of the positive feelings he has toward him.

This exercise evoked much feeling in the group. In each meeting almost all of the group members wanted to be "it." The teenagers were visibly delighted when they received positive feedback. When a teenager who was "it" heard a strength identifier that he did not expect to hear, he usually reacted with surprise—saying, "who, me?" "you must be kidding" or "I am not like this at all." We encouraged expressions of positive feelings.

3. **Blind walk.** The participants divide into two member teams, with one member playing the role of leader and the other of blind follower. Closing their eyes, the follower relies on the leader to take his hand and guide him on a walk around the classroom. After 5 minutes, the members exchange roles.

In this exercise, three teachers and two other counselors who had expressed interest in sensitivity training joined our group. Each adult was paired with a teenager and the other teenagers worked with each other. The leaders were instructed to try to provide experiences in which the blind partner would substitute the senses of touch, hearing, and smell for sight; followers were instructed to use all their other faculties to perceive what was happening and determine the mood of those in the room without opening their eyes.

After everyone in the group had played both roles, the members discussed what they had learned. Teachers and counselors said that being dependent on a teenager sharpened their awareness of leader-follower relationships with students. Students, in turn, they gained a clearer understanding of some of the teachers' problems.

4. **Free time.** During this exercise each group member teams up with another one to plan and engage in a 10-minute activity.

The group members liked this exercise because it enabled them to make noise and be physically active in the classroom without being censored or stopped. The most popular activities included mock fighting, boxing, particularly between the boys; playing guitar; dictating into the tape recorder; singing "out" songs; telling jokes; and planning a party.

5. **Expressing negative feelings.** A "speaker" selected members of the group sits in the center of a circle and expresses his negative feelings toward teachers, principals, other members of the school staff, and other students. Then another "speaker" is selected to do the same.

For many group members, this exercise was more difficult than strength bombardment. As we expected, it was harder for the students to deal with their negative feelings than their positive emotions. Initially, we encountered much reluctance to talk about negative feelings, but as the group developed, more students became able to express the hostility they felt toward school and persons in the school environment. When a "speaker" expressed dislike of other students, a prolonged, angry exchange with members of the group often ensued.

We found that although this experience evoked confusion, most students could accept the criticism and deal with it constructively. We felt our role was to help them to understand the anger and let the student express it verbally, but not physically. We tried to encourage the students to explore further the feelings they had toward other persons and what such feelings meant to themselves and to others.

Although they did not seem to feel guilty when expressing anger toward teachers, many obviously felt guilty when expressing negative feelings toward other students. We were primarily concerned with

helping the teenager who felt guilty toward another student become able to communicate his feelings to the members of the sensitivity training group, who in turn would react with each other on different levels of awareness. As the teenagers learned to share their feelings, members of the sensitivity group developed greater trust in each other.

In one instance a teenager's negative comment about another member of the group provided the stimulus for a physical confrontation. The boy who was "put down" threw a chair at the "speaker" and they began to fight. Both were gasping for breath when we separated them. After an emotional discussion by the entire group, the two students made up. During the remainder of the program they became close friends.

Student and teacher reactions

We received many reports from teachers that the students attending the program were enthusiastic about it. Several of the students approached their teachers to tell them what went on in the group. We encouraged the teachers to listen and to help these students transfer their enthusiasm to their own classroom.

We also encouraged some of the students who expressed continuing anger toward authority figures to tell their teachers about it. We found that in those students who did so, a change occurred in their perception of their teachers and school. Students reported that in many instances when they expressed some negative feelings, the teachers seemed to appreciate their frankness. Toward the end of the experiment many of the students asked to participate in future groups. Some of those students were invited to discuss their ideas with the unity team, which was then planning a similar program for the next school year. Some of their comments:

"I like this best of all my subjects." "It's a cool program." "Boy, it's really great to come in here and do what you feel like doing." "I didn't know school could do this for me."

The majority of the teachers who had students in the program were highly supportive. Some teachers, however, complained that their students' perceptions of them were inaccurate and the criticisms were unfair. We dealt with these teachers individually, inviting them to observe or participate in the sensitivity training exercises to help them understand the nature of the students' interaction.

Near the end of the 1969-70 school year, with the

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support of the unity team, we initiated a staff development program designed to improve the skills of the entire faculty in solving behavioral problems of students, in dealing with situations involving other interpersonal relationships, and in increasing inter-staff communication. This program ran concurrently with the sensitivity training.

Some observations

Initially we hesitated to embark upon the program because we did not know how it would turn out, and because we anticipated less than enthusiastic support from students and faculty. As the program progressed, our perception became clearer and we became more confident that sensitivity training can have a meaningful effect on the school. Many teachers told us that changes had occurred in their own attitudes toward the students in our group, whom they now perceived more positively than before the group began.

Incidents of truancy and aggression among the students who participated in sensitivity training were lower last spring than at the beginning of the program. Based on this and other results achieved in the 1969-70 group, my coleader and other school counselors are conducting another sensitivity training group this year.

I am convinced that sensitivity training has major potential for use with junior high school students who present behavior problems during school hours. The group experience helps such students view their own behavior, as well as their teachers' and other students' behavior, in a different light. Many of the teenagers who participated in our group, for example, have increased their social sensitivity as well as their behavioral flexibility, and are now able to act more appropriately in interpersonal situations with other students and their teachers.

¹ Garwood, D. S.: The significance and dynamics of sensitivity training programs. *International Journal of Group Psychotherapy*, October 1969.

² Hanson, P. G.; Rothaus, P.; Johnson, D. L.; Lyle, F. A.: Autonomic groups in human relations training for psychiatric patients. *Journal of Applied Behavioral Science*, July-September 1966.

³ Harrison, R.: Cognitive change and participation in a sensitivity training laboratory. *Journal of Consulting Psychology*, December 1966.

⁴ Lakin, M.; Garson, R. C.: A therapeutic vehicle in search of a theory of therapy. *Journal of Applied Behavioral Science*, January-March 1967.

⁵ Rubin, I.: The reduction of prejudice through laboratory training. *Journal of Applied Behavioral Science*, January-March 1967.

⁶ Pollack, D.: A sensitivity training approach to group therapy with children. Unpublished paper delivered to a PTA meeting at the guidance center, Los Angeles, Calif. 1969.

⁷ Rueveni, U.: Using encounter group techniques in the treatment of the social network of the schizophrenic. *International Journal of Group Psychotherapy*, October 1969.

collected readings

COGNITIVE STUDIES. Edited by Jerome Hellmuth. Brunner/Mazel, Inc., 80 East 11th Street, New York, N.Y. 10003. 1970. 511 pp. \$12.50.

CHILD WELFARE SERVICES: a sourcebook. Alfred Kadushin. The Macmillan Co., 866 Third Avenue, New York, N.Y. 10022. 1970. 544 pp. \$8.95.

CHILD DEVELOPMENT AND BEHAVIOR. Edited by Freda Rebellsky and Lynn Dorman. Random House, Alfred A. Knopf, The College Department, 201 East 50th Street, New York, N.Y. 10022. 1970. 399 pp. \$5.95.

NEW APPROACHES IN CHILD GUIDANCE. Herbert S. Strean, editor. Scarecrow Press, Inc., Post Office Box 656, Metuchen, N.J. 08840. 1970. 313 pp. \$7.50.

SOCIAL WORK AND MENTAL RETARDATION. Meyer Schreiber, editor. The John Day Company, Inc., 62 W. 45th Street, New York, N.Y. 10036. 1970. 758 pp. \$12.95.

MINNESOTA SYMPOSIA ON CHILD PSYCHOLOGY. John P. Hill, editor. University of Minnesota Press, Minneapolis, Minn. 55455. 1970. 275 pp. \$5.

HUMAN SEXUAL DEVELOPMENT: perspectives in sex education. Donald L. Taylor, editor. F. A. Davis, 1915 Arch Street, Philadelphia, Pa. 19103. 1970. 407 pp. \$5.95.

PROGRAM EVALUATION IN THE HEALTH FIELDS. Herbert C. Selberg, Alan Sheldon, and Frank Bal editors. Behavioral Publications, 12852 Broadway-Morningside Heights, New York, N.Y. 10025. 1970. 582 pp. \$19.95.

CHILD & ADOLESCENT PSYCHOLOGY: a book of readings. Gene Medinmus and Ronald C. Johns editors. John Wiley & Sons, Inc., Third Avenue, New York, N.Y. 10016. 1970. 662 pp. \$9.95 cloth, \$5.95 paper.

ANNUAL PROGRESS IN CHILD PSYCHIATRY AND CHILD DEVELOPMENT. Stella Chess, M.D., and Alexander Thomas, M.D., editors. Brunner/Mazel Publishers, 80 East 11th Street, New York, N.Y. 10003. 1970. 585 pp. \$15.

BOOK NOTES

SOCIETY AND DRUGS. Drugs I: social and cultural observations, 400 pp. **STUDENTS AND DRUGS.** Drugs II: college and high school observations, 399 pp. Richard H. Blum and Associates. Jossey-Bass Inc., San Francisco, Calif. 1969. \$12.50 each.

These two volumes explore the facts surrounding changing cultural patterns—the use of psychoactive drugs, including tobacco and alcohol as well as marijuana, the amphetamines, and the various hallucinogenic substances. They discuss the characteristics of persons most likely to use drugs, conditions associated with drug use, and some of the psychological and social causes and results of drug use today.

Volume I presents historical information on the use of various kinds of drugs and recent data on drug use in different parts of the world—including the hippie “subculture”—and discusses the effects of drug use on health, behavior, and crime. It finds “no clear conclusion possible” as to the effects of prohibitive laws in reducing health risks to drug users or in reducing crime.

Volume II discusses some of the data on experiences with drugs obtained from interviews with more than 20,000 young persons—mostly students in five Western colleges—in 1966, 1967, and 1968. From one-third to one-tenth of the college students said they had had some experience with marijuana—about the same percentages as for amphetamines. During the 3-year period the interviewers found a “remarkable” increase in drug use among students.

A chapter on drugs and high school students presents data from surveys in four schools in the San Francisco Bay area on use of tobacco, alcohol, marijuana, hallucinogens, heroin, stimulants, glue, and other substances; the influence of friends on students' decisions to use drugs; opportunities for using drugs; and students' attitudes toward drug usage. Citing the increasing use of illicit drugs—particularly

marijuana—among high school and elementary school students, Dr. Blum suggests in the epilogue that as a group younger students are less able than college students to handle the emotional concomitants of strong psychoactive drugs.

LETTER TO A TEACHER. The school-boys of Barbiana. Translation and introduction by Nora Rossi and Tom Cole. Postscripts by Robert Coles, M.D., and John Holt. Random House, New York, N.Y. 1970. 167 pp. \$4.95.

A picture-graph on page 51 of this book summarizes a class followed through 8 years of public schooling in Italy. The text explains: “This class has lost forty children. Sixteen went to work . . . twenty-four are repeaters. Altogether, fifty-six children have passed through this class. By the third year of intermediate, we find only eleven out of the thirty-two original students. . . .” The survivors were the children of the rich; the missing, the children of poverty, who need education to escape the poverty cycle.

The authors, eight Italian peasant boys who participated in a free and freeing school provided by a priest in the tiny village of Barbiana, dissect the public school teachers and the systems that have long perpetuated drop-out proportions that “began to scream in your face”; then they propose and elaborate on three reforms: (1) do not fail students, (2) give a full-time school to children who seem stupid, and (3) give a purpose to the lazy.

The letter was composed as a class project in a school where grades are unknown, boys work together to solve problems related to the human experience, elders teach youngsters, the “favorite” is the child who finds learning difficult, and the goal is to advance together.

In his postscript, Dr. Coles reports that he has found the same sense of comradeship and the same sense of “can-

dor and concrete aphoristic wisdom” in American boys in urban ghettos and on tenant farms. “What is truly remarkable,” he says of the young Italian authors “. . . is the almost uncanny mixture of rebelliousness and compassion that these youth show—compassion for the very exploiters they so roundly denounce. . . .”

Dr. Holt asks, “What has this eloquent angry book . . . to do with America . . . ?” And he answers: “These boys *are* ours; their voices cry out to us; their counterparts—black, Puerto Rican, Mexican, Asian, Indian—are talking or shouting in school after school, on campus after campus, the same message into our ears. We must learn, soon, while we still have time, to hear what they say.”

VIOLENCE AGAINST CHILDREN: physical child abuse in the United States. David G. Gil. Harvard University Press, Cambridge, Mass. 1970. 204 pp. \$6.50.

To present a picture of the extent and background of child abuse in the United States, this book analyzes a series of studies carried out under the author's supervision at Brandeis University during 1965–68 through a grant from the Children's Bureau. These studies included analyses of nationwide press reports and public opinion surveys, of nearly 13,000 incidents of child abuse reported through legal channels across the country during 1967–68, and of a detailed study of more than 1,300 incidents of abuse reported in a representative sample of cities and counties.

Interpreting these surveys, the author offers a social and cultural explanation of child abuse in the United States, rather than a psychological or clinical one. He suggests that violence against children in America is based not only on the personality disorders of parents, but also on a traditional, accepted use of physical force against youngsters in this country. He finds that belief in the adage “spare the rod and spoil the child” by many Americans encourages extreme forms of child abuse on the part of some parents with psychological and social problems.

In referring to the book's series of tables summarizing the findings of the surveys, the author points out that these show more cases of child abuse

among broken and large families in socially and educationally disadvantaged groups of the population. In his final chapter, he recommends educational efforts to change permissive American attitudes toward the use of force on children, and also laws against corporal punishment in homes, schools, courts, and child care facilities.

CHILDREN AND YOUTH IN AMERICA: a documentary history. Volume I, 1600-1865. Edited by Robert H. Bremner. Harvard University Press, Cambridge, Mass. 1970. S36 pp. \$10.

What life was like for children in America from early settlers in the Massachusetts and Virginia colonies to the 19th century immigrants from Middle Europe is revealed by their contemporaries in the documents that make up this book—records of colonizing companies, excerpts from diaries, letters

back home, sermons, essays, laws, organizational papers, annual reports, and other original sources.

Beginning with a report to London authorities on 100 children sent to Virginia who "there safely arrived (save such as died on the way)," it presents firsthand evidence of what was expected of children by their own families and by others when they had no families. The picture is largely one of exploitation, often sincerely regarded for the children's own good—as when children are indentured or "bound out" to work in families that will give them a home, or when an Omaha Indian family requires little girls to carry out heavy work in the home and in the fields—but often with no regard for the child at all. Excerpts from Fanny Kemble's letters as a bride newly arrived in Georgia, for example, reveal her shock at conditions she found among the slave children on "an estate where the owners

are supposed to be humane."

But evidence of the concern that led to reform are here too—from letters of English authorities pleading for a stop to the practice of kidnaping children for shipment to the New World, to documents of the early movements for provision of public education, to founding of the early orphanages. "vagrant, destitute, and dangerous children," the beginnings of studies of hazards to child health, and the founding of comprehensive service organizations such as the New York Association for the Improvement of the Poor.

The book is the first of three volumes to present a documentary history of public policy in regard to children. Volume II will cover events between 1865 and 1932; Volume III from 1933 to the present. Their publication has been sponsored by the American Public Health Association, under a grant from the Children's Bureau.

guides and reports

DISTURBING THE STATUS QUO. Georgia L. McMurray. **MOBILIZING OFFICIALDOM AND VOLUNTEERS.** Mrs. Moses Blitzer. Florence Crittenton Association of America, 608 South Dearborn Street, Chicago. Ill. 60605. 1970. 14 pp. 50 cents.

Describes steps taken by the Public Education Association to provide education for pregnant schoolage girls in New York City.

DAY CARE REFERENCE SOURCES— an annotated bibliography, May 1970. Institute for Interdisciplinary Studies, American Rehabilitation Foundation, 123 East Grant Street, Minneapolis, Minn. 55403. 1970. 29 pp. \$2.

Lists publications on day care and related subjects that are available from the Federal government and national voluntary organizations.

A CHANCE FOR EVERY CHILD— the case for children's allowances. Maxwell S. Stewart. Public Affairs Com-

mittee, 381 Park Avenue South, New York, N.Y. 10016. Public Affairs Pamphlet No. 444. 1970. 24 pp. 25 cents.

Presents arguments for and against provision of allowances for children in the United States, regardless of the family's income.

COMMUNICATION AND THE DISADVANTAGED CHILD. William G. Hardy. Williams & Wilkins Co., 428 E. Preston Street, Baltimore, Md. 21202. 1970. 195 pp. \$9.95.

Reports on a conference sponsored by the Children's Bureau at Johns Hopkins University in 1969 that explored problems of communication of young children in the innercity and the possibility of including communications training in day care programs.

THE GOOD SEED: library planning for urban disadvantaged children age 3 to 7. (Proceedings of an institute funded under title II-B of the Higher

Education Act.) Department of Librarianship, Western Michigan University, Kalamazoo, Mich. 49001. 1970. 30 pp. \$1.65.

Describes ways school and public librarians can work together to develop cooperative community programs in innercity preschool and primary grade children.

EDUCATION FOR THE LESS PRIVILEGED. IDEA, Information Services Division, P.O. Box 446, Melbourne, Fla. 32901. 1970. 24 pp. \$1.

Reports a 3-day conference held in Oxfordshire, England, with representatives from the United States, Canada and Great Britain to establish a change of information and ideas.

WHAT YOU MUST KNOW ABOUT DRUGS. Harvey R. Greenberg. Stochastic Book Services, 50 West 4th Street, New York, N.Y. 10036. 1970. 160 pp. 95 cents.

Directed to junior and senior high school students, this book describes various drugs and their effects and includes directories of treatment agencies and telephone numbers for direct help.

HERE and THERE



Federal legislation

The 91st Congress passed, and the President signed into law, a number of measures that will affect the health and welfare of children in the United States. They include:

The Lead-based Paint Poisoning Prevention Act of 1970 (Public Law 695).

This act authorizes appropriations to a total of \$30 million for fiscal years 1971 and 1972 for local activities to eliminate lead-based paint poisoning, including—

A total of \$9.9 million for the 2 years for Federal grants, to be made by the Secretary of Health, Education, and Welfare to units of local governments to develop and conduct comprehensive programs for detecting and treating poisoning from lead-based paint. Such programs are to include: (1) education of parents, educators, and health officials about the dangers and prevalence of lead poisoning among children in inner-city areas, (2) intensive community testing to detect incidents of lead poisoning and to insure prompt medical treatment of afflicted children, (3) intensive followup procedures to insure that children who have been treated are protected against further exposure, and (4) any other actions that will reduce or eliminate lead poisoning. Each local program is required to provide training and employment opportunities for residents of communities or neighborhoods affected by lead poisoning. Grants may pay up to 75 percent of the cost of developing and operating local programs.

\$15 million for the 2 years for grants to be made by the Secretary of Health, Education, and Welfare to units of local governments to develop and carry out programs to iden-

tify high-risk areas and eliminate the hazards of lead-based paint, employing residents of affected communities in the programs when feasible. Such programs are to include: (1) testing to detect the presence of lead-based paint on the surfaces of residential housing, and (2) prompt elimination of lead-based paints from all surfaces of residential housing to which children are exposed, including those on which lead-based paint has been covered by non-lead-based paint, and (3) any other actions that will reduce poisoning from lead-based paint.

• \$5 million for the 2 years for a Federal demonstration and research program conducted by the Secretary of Housing and Urban Development in consultation with the Secretary of HEW to determine the nature and extent of lead-based paint poisoning in the United States, particularly in urban areas, and the most effective methods for removing such paint from the surfaces of residential housing.

The act calls for a report to Congress within a year on research findings, with recommendations for program and legislation.

The act also requires the Secretary of HEW to prohibit the future use of lead-based paint in residential structures constructed or rehabilitated by the Federal Government or with Federal assistance in any form.

The Family Planning Services and Population Research Act of 1970 (P.L. 91-572).

This act authorizes appropriations up to a total of \$382 million for the operation of family planning programs and population research during fiscal years 1971, 1972, and 1973, including—

• A total of \$180 million for 3 years, for project grants to public or nonprofit private entities to assist in the estab-

lishment and operation of voluntary family planning projects.

• \$45 million for the 3 years, for formula grants to State health authorities to assist in planning, establishing, maintaining, coordinating, and evaluating family planning services under a coordinated and comprehensive State program of family planning services.

• \$9 million for 3 years, for training grants to public or nonprofit private entities and individuals to train personnel for family planning services.

• \$145 million for the 3 years, for research grants to public or nonprofit private entities and individuals to promote research in biomedical, contraceptive development, and behavioral fields, and in program implementation related to family planning and population.

• \$3 million for the 3 years, for informational and educational grants to individuals and public or nonprofit private entities to assist in developing educational materials and making information on family planning and population growth available to all persons desiring such information.

All grants are to be made by the Secretary of Health, Education, and Welfare.

The act specifically prohibits the expenditure of such funds in programs in which abortion is used as a method of family planning.

No charge may be made to any person from a low-income family for family planning services provided under the act. Furthermore, it provides that no agency may require acceptance of family planning as a prerequisite for eligibility or receipt of another service of the agency.

The act mandates an Office of Population Affairs in the Department of Health, Education, and Welfare, directed by a Deputy Assistant Secretary for Population Affairs, to administer, coordinate, and evaluate HEW's activities in family planning and population research, serve as a liaison with other Federal agencies having such programs, provide a clearinghouse of information on domestic and international activities, and provide or support manpower training for family planning services and research.

The act requires the Secretary of HEW to present Congress a 5-year plan by the end of June 1971 for extension of family planning services to all persons desiring such services, programs in fam-

ily planning and population research, and manpower training; and to report to Congress on each January 1 for the ensuing 5 years on the results achieved.

The Poison Prevention Packaging Act of 1970 (P.L. 91-601).

The act authorizes the Secretary of HEW to set Federal standards for special packaging of any household substance that by reason of its packaging has been found to present a hazard in its availability to children. "Special package" is defined as packaging "designed to be significantly difficult for children under 5 years of age to open or to obtain a toxic or harmful amount of the substance contained therein within a reasonable time and not difficult for normal adults to use properly."

The act states, however, that the term does not mean packaging that all children under 5 cannot open within a reasonable time. It authorizes the Secretary, in setting regulations under the act, to prohibit packaging that he determines is unnecessarily attractive to children.

It requires the Secretary to appoint a technical advisory committee, composed of up to 18 representatives of Government, manufacturers, scientists, medical practitioners, and consumers to assist him in establishing standards under the act.

To accommodate elderly or handicapped persons unable to use a substance when packaged in compliance with the standard, the act permits a manufacturer an exemption for packaging of a single size if the product is labeled: "This package for households without young children." Products requiring prescriptions by licensed medical practitioners may be dispensed in such non-complying packages only on order of the prescriber; others, only at the request of the purchaser.

The Developmental Disabilities Services and Facilities Construction Amendments of 1970 (P.L. 91-517).

The act amends the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 to provide for assistance to States in developing and implementing plans for comprehensive services to persons affected by a disability "attribut-

able to mental retardation, cerebral palsy, epilepsy, or another neurological condition" that has originated before the age of 18, has continued or can be expected to continue indefinitely, and constitutes a substantial handicap.

The act authorizes appropriations for fiscal years 1971, 1972, and 1973, totaling—

- \$285 million for formula grants to be made by the Secretary of HEW to the States for developing and implementing a comprehensive plan for services to persons with developmental disabilities; construction of facilities for public or nonprofit private agencies; provision of services, including costs of operating, staffing, and maintenance of facilities; State and local planning, administration, and technical assistance relating to services and facilities; training of specialized personnel; and development or demonstration of new or improved techniques for provision of services for persons with developmental disabilities.

- \$52 million for project grants to be made by the Secretary of HEW to colleges, universities, or public and nonprofit agencies for operating demonstration facilities and interdisciplinary training programs. The act requires priority to be given to applicants who have made arrangements for a junior college to participate in the program.

The act also requires the Secretary of HEW to appoint a 20-member National Advisory Council on Services and Facilities for the Developmentally Disabled by July 1, 1971.

The Comprehensive Drug Abuse Prevention and Control Act of 1970 (P.L. 91-513).

This act amends the Public Health Services Act, the Community Mental Health Services Act, and other laws to provide for increased research; increased preventive and rehabilitative activities relating to drug abuse; and strengthened authority for enforcement of laws relating to drug abuse and the control of drug traffic.

The act also provides for education against drug abuse by authorizing the Secretary of HEW to make grants to States, other governmental units, and public and nonprofit agencies for preparation of materials about drugs and the development and evaluation of programs directed to the general public,

school-age children, and special high risk groups; and, through the National Institute of Mental Health, to collect, prepare, and disseminate information about drug abuse, conduct programs of public education, and train persons engaged in educational programs about drug abuse. It authorizes appropriations up to a total of \$29 million through 1973 for such educational activities.

The Drug Abuse Education Act of 1970 (P.L. 91-527).

This act authorizes appropriations up to a total of \$58 million for fiscal years 1971, 1972, and 1973, including—

- \$29 million for project grants; contracts to be made by the Secretary of HEW for the 3 years, to educational institutions, States, other governmental units, and public and nonprofit agencies to support research, demonstration, and pilot projects related to educational programs and activities on the use of drugs. These may include such activities as development of curricula for elementary, secondary, and community education programs on use and abuse of drugs; preparatory dissemination, and evaluation of materials; and operation of training programs.

- \$29 million for grants or contracts to be made by the Secretary of HEW for the 3 years, to public or private agencies, organizations, and institutions for planning and carrying out community-oriented educational programs on drug abuse. Such programs may include workshops, telephone counseling and information services, operation of centers open to persons seeking to discuss or obtain information, advice, or assistance on drug abuse or problems of drug dependence.

Transracial adoptions

Adoption of black children by white families increased from 23 percent of the placements by public and voluntary agencies in 1968 to 33 percent in 1970 according to a nationwide survey conducted by Opportunity, a program of the Boys and Girls Aid Society of Chicago to encourage adoption of black and racially mixed children. The 342 State, county, and local agencies responding to the survey made an estimated 10 percent of the Nation's adoption placements.

its of black children in 1969. Fifty-
at of the agencies did not place any
k children, however.

he survey for 1969 shows that 4,336
k children were placed by 284 agen-
—2,889 children with black families
1,147 with white families. Of these,
agencies placed black children only
black families and 47 agencies
ed black children only with white
ilies. Private agencies placed
tly more than half of the chil-
n—2,208.

he 1969 survey included 166 agen-
that had answered Opportunity's
questionnaire for 1968. These agen-
placed a total of 2,598 black chil-
for adoption in 1968 and 3,224 in
—an increase of 24 percent in a
le year. During the same period the
ber of black children placed with
te families through these agencies
eased 81 percent and the number
ed with black families increased 5
ent. These findings suggest that in-
acial placement offers the major
ns of increasing the opportunities
adoption of black children, accord-
to Opportunity director Charles B.
s.

uth conference

he White House Conference on
th is to be held in Estes Park, Colo.,
il 18-22. The 1,500 delegates will
ude 1,000 young people from the
s of 14 through 24 from all sections
he United States and 500 adults who
local, State, or national leaders in
cation, business, professions, govern-
nt, and voluntary organizations. The
ference will be divided into 10
ups, made up of two-thirds young
ple and one-third adults. Each group
discuss one of 10 topics—such as
gs, poverty, education, foreign rela-
s, and race and minority relations—
a members of a task force that has
n investigating the topic since last
mer.

andoned infants

he apparently steady rise in the
ber of well infants left as "board-
" in the District of Columbia General
pital, the municipal hospital in
hington, D.C., prompted two mem-
s of the Pediatrics Department—
omas E. Reichelderfer, chief medical
er, and Andrew J. Cary, medical

social worker—to undertake a study
early last year of the extent and nature
of the problem there and, through
mailed questionnaires, in similar hos-
pitals in 10 other major cities.

The investigators found that the num-
ber of infant "boarders" received at
D.C. General had risen from 130 in 1963
to 151 in 1969. An analysis of the 151
received in 1969 showed that 51 percent
had been delivered in the hospital and
left there by the mother—some in delib-
erate abandonment and others because
the mother had failed to make appro-
priate arrangements for the child's care
on discharge; 22 percent had been
brought to the hospital by agents of the
District of Columbia Department of
Public Welfare; 17 percent had been
brought by the police; and 10 percent
had arrived through various other local
agencies.

The hospital's social service records
contained the following reasons for the
mother's not keeping the child: Mother
wishes the child to be placed for adop-
tion, 28 percent; has abandoned the
child, 21 percent; is unable to support
the child, 16 percent; is mentally ill or
retarded, 10 percent; is suffering from
drug addiction, 6 percent. Other rea-
sons, noted less frequently, were unsat-
isfactory housing, incarceration, dis-
appearance, or chronic illness.

Well over half of the mothers of these
infants (55 percent) were over 21 years
of age; 17 percent were between the
ages of 17 and 21; and 12 percent were
under 17. The ages of the other 1 percent
were unknown. Seventy percent of the
mothers were single, 16 percent were
married, and the rest were separated,
divorced, or widowed. Only 12 of the
mothers—8 percent—were part of a
stable family unit in a marital or com-
mon-law relationship.

The infant boarders stayed in the
hospital from less than 2 weeks to 6
months, but the great majority (86
percent) left within 4 weeks. On dis-
charge, 70 percent were placed in family
homes—35 percent with their own
mothers, 23 percent in foster homes, and
12 percent with relatives or in adoptive
homes. The rest were placed in chil-
dren's institutions.

About half the infants of teenage
mothers, two-fifths of the infants of 20
to 25 year old mothers, and one-third of
those of mothers over 26 were returned
to their mothers or other relatives.
Ninety-four percent of those whose

mothers were over 21 and had had previ-
ous children were rejected by their
mothers, compared with 66 percent of
those with teenage mothers who had
had previous children.

The investigators attribute a great
part of D.C. General's problem of "in-
fant boarders" to the fact that in Wash-
ington, where most of the abandoned
children are black (in line with the
city's population), few adoptive homes
for black children are available through
social service channels, and foster
homes are scarce because of the in-
adequacy of payments for care. They
point out that to care for a well child
in the hospital costs the city \$94 a day
as compared with the \$80 a month the
city pays for care in a foster family
home. They also point out that keeping
well infants in a hospital exposes them
to illness and uses beds needed by sick
children.

Seven of the 10 other hospitals sur-
veyed reported infant boarder problems
similar to D.C. General's. The three
others—in Baltimore, Dallas, and Los
Angeles—had arrangements with local
social agencies whereby all abandoned
children received at the hospital are sent
within 24 hours to foster homes, way
stations, convalescent hospitals, or
adoption agencies.

Children's lobby

The Children's Lobby, a voluntary
national association of persons and
groups seeking public support of pro-
grams benefiting children, youth, and
families, was formally created in Wash-
ington, D.C., December 13, 1970, at an
open meeting held before the official
opening of the White House Confer-
ence on Children. More than 400 persons
attended—professional and nonprofes-
sional persons in programs that serve
children, parents of children in such
programs, representatives of various
ethnic groups, and community, business,
labor, and religious leaders.

The new organization will lobby for
legislation and appropriations at Fed-
eral, State, and local levels in support
of maternal and child health, nutrition,
education, child development and day
care, youth activities, recreation, delin-
quency prevention and control, parent
education, and programs for children
with special needs, including the phys-
ically and mentally handicapped. It
will also develop legislative support for

programs and policies suggested by other national organizations.

The Children's Lobby will be supported entirely by contributions and membership dues from individuals and organizations.

Jule M. Sugarman, administrator of human resources for the city of New York, is chairman of the interim organizing committee of Children's Lobby. (Address: Children's Lobby, 110 Riverside Drive, New York, N.Y. 10024.)

Retarded children

In less than a year, a program of environmental enrichment and training in personal hygiene and self-help provided in a familylike setting resulted in significant gains in social maturity among 41 retarded children at the Utah State Training School, according to Tony La Pray, the program director. On the Vineland Social Maturity Scale, which measures a child's ability to look after his own needs and take responsibility for carrying out tasks, the average "social quotient" of the children increased from 30.9 in September 1969 to 34.7 in June 1970.

Provided by the Brigham Young University and the University of Utah through a grant from the Public Health Service, the program was designed to help severely and moderately retarded children between 5 and 12 years of age develop social competence and learn basic self-help skills that would qualify them for enrollment in school. The children were placed in a separate building in four "family" units, each headed by two attendants who acted as parents. After being trained in operant conditioning, the attendants lived with the children and provided them with toilet training and guidance in other aspects of personal hygiene. In addition, four full-time teachers worked with all groups of children in language, perceptual, and concept development; music and dancing; arts and crafts; and recreation and supervised play.

By the end of the year, all the children showed improvement in bathing, showering, eating, dressing, undressing, self-toileting, and communication about their needs and in performing such "family" tasks as picking up their clothes and making their beds.

Several children were able to enter a more advanced preschool program or school itself in the fall of 1970. In con-

trast, a group of randomly selected children showed no change in performance during the school year. The program is being continued with another group of children during the 1970-71 academic year.

Child care

The 4-C Division of the Office of Child Development and the Child Development Program of the Appalachian Regional Commission are conducting a joint project to train 22 coordinators and assistant coordinators in 1971. Upon completion of 1 week of formal classes and a period of supervised work experience in OCD regional offices in Appalachia, the coordinators will be permanently assigned to give technical assistance in setting up State and local community coordinated child care organizations and to assist Federal regional 4-C committees in their work.

Child development staff members of the Appalachian Regional Commission conducted classes in Washington, D.C., in February and March. The trainees, most of whom previously worked in community organization programs, were selected by assistant regional directors for OCD. Trainees in the first group came from the Appalachian States, which lie within HEW regions II, III, IV, and V. Trainees from the other six HEW regions were in the second group.

• • •

In February 1971, the Department of Health, Education, and Welfare opened a day-care center for 60 preschool children of employees who work in the Washington, D.C., headquarters.

The HEW center is being supported through a Federal grant from the Social and Rehabilitation Service, Community Services Administration and by fees charged parents on a sliding scale.

The center is open from 7:30 a.m. to 6 p.m. Monday through Friday. It serves the children a hot breakfast, a hot lunch, and two snacks. Emergency health service is available in the Department. In late spring the children will move from temporary quarters to the penthouse of the main HEW building, which is now being renovated for the purpose.

The children, who are from 2 to 5 years old, are assigned to a class with others of the same age. Each of the four classes has 15 children, one teacher,

one paraprofessional aide, and one trainee in child care under the W. Incentive Program. In addition, the center has a full-time director and educational specialist.

To obtain a cross section of the children of HEW employees, an eight-member parents' advisory committee and the director developed the following criteria for selecting children: at least 50 percent to come from families with low income; the children to be evenly divided between the sexes; at least one-fourth of the children to be in the age group from 2 through 5.

The center is operated by Thermo Chemical Corp. as contractor.

Child development

A program to encourage mothers to improve the frequency and quality of their verbal contacts with their children, underway in the Bronx, New York City, is also providing high school students with opportunities to learn ways of relating to young children. Now in its second year, the program is sponsored by the board of education of the city of New York with the use of Federal funds provided under title III of the Elementary and Secondary Education Act.

The program provides service to a total of forty 3-year-old nursery school children, their younger siblings, and their mothers. The mothers and children meet in small groups in the city every school twice a week for an hour a quarter each session. The mothers serve the children playing under supervision of a nursery school teacher and afterwards discuss, with another teacher, ways in which adults can relate to children and other topics pertinent to child development and family living. The teachers' emphasis is on how to provide rich experiences to children in life, especially through talking with the child. Coffee is served to the mothers, and simple craftwork is employed to facilitate free and relaxed discussion.

The students, seniors from a nearby high school, participate in the program once a week as assistants to the nursery school teachers. They are instructed in methods of talking with children without intruding on their play or limiting their personal discoveries.

The program is under the direction of Seymour J. Perlin. (Address: Elementary Language Program, 698 East 104th Street, Bronx, N.Y. 10456.)

IN THE JOURNALS

Institutionalized infants

Noting that many abandoned or neglected infants today are being cared for in hospitals or institutions because alternatives seem to be available for them, an article in the *Medical Annals of the District of Columbia* for November 1970 describes a study of 31 infants cared for in four institutions in the Washington area and a resultant attempt to help institutional nurses find ways within their busy routines of stimulating the babies' development. ("Enhancing the Development of Institutionalized Infants," by Ann Lodge, Ph. D., Dorothy S. Huntington, Ph. D., Mary E. Pinson, Ph. D., and Judith Lewis, A.)

The authors, all staff members of the child development section of Children's Hospital in Washington, which made the study, report that at 6 months of age the children under study—all normal at birth—showed developmental delays in gross motor coordination, fine motor coordination, exploratory activity, purposive goal-directed behavior, receptive cognitive performance, social responsiveness, and expressive vocalization, scoring a mean "mental age" of 4 months. In contrast, four "boarder babies" who were assigned to hospital staff members for at least 30 minutes of mothering 4 days a week from the age of 6 weeks or younger, at age 6 months scored a mean mental age of 12 months, and had advanced further than the other babies in nearly all areas of functioning.

As a result of these findings, the authors report, the child development section is working with the four institutions to educate their nursing staffs to developmental needs of infants and help them find practical methods of child management that will bring infants more stimulation. From this experience the authors list a number of requirements for bringing about institutional change. In brief these are:

Staff education regarding the im-

portance of reaching out to very young children.

- Periodic evaluations of every child resulting in individual developmental prescriptions.
- Sufficient staff to provide each child with a sustained one-to-one interaction.
- Provision for getting babies out of their cribs and out of their rooms.
- Institutional support for the program.

School-age nutrition

"Man has remarkable powers of adaptation, but there is a definite limit to his ability to adapt to an inadequate intake of nutrients, particularly in the case of the growing child," says E. Neige Todhunter, Ph. D., in an article stressing the importance of school feeding programs in the December 1970 issue of the *American Journal of Public Health*. ("School Feeding from a Nutritionist's Point of View.")

The author, visiting professor of nutrition at Vanderbilt University School of Medicine, points out that dietary studies have repeatedly shown inadequacies—especially in calcium, iron, vitamin A, and ascorbic acid—in school-age boys and girls. The nutritionist, she says, has a responsibility to look closely at reports that gloss over such inadequacies with such statements as "the majority met the recommended allowances." Pointing out that majority can mean anything over 50 percent, she asks, "What about the other 40 percent or more?"

The author recommends school feeding programs as a means of remedying such inadequacies and recognizes no excuse for a school's failure to provide them. However, she points to some barriers to the appropriate use of many programs already in existence: the inability of some children to pay; poor facilities and poor class scheduling making it difficult for the children to participate; and children's cultural and psychological reactions to certain foods.

School feeding programs, the author maintains, should be: (1) part of the total school program, (2) run on a non-profit basis, (3) charge no more than the parents can afford to pay, (4) serve simple meals suited to the cultural background and habits of the child, (5) supply at least a third of the recommended daily dietary allowance of nutrients, (6) introduce the child to new foods, and (7) include nutrition education provided through the united efforts of classroom teachers and food service personnel.

AFDC characteristics

The average stay of families in the program of aid to families with dependent children (AFDC) dropped from over 25 months (2.1 years) in 1967 to 23 months in 1969, according to an article in the September-October 1970 *Welfare in Review*. ("The AFDC Family in the 1960's" by David B. Eppley.)

The author, at the time of writing, a research analyst in the National Center for Social Statistics, Social and Rehabilitation Service, compares the findings of three studies made in 1961, 1967, and 1969. He points out other differences in 1969 from the 2 earlier years: more recipients lived in cities; more were without fathers in the home; a lesser proportion—though still more than half—were white (50.5 percent as against 51.9 percent in 1961).

Among other data the article presents regarding the families on AFDC in 1969:

- One-third of all the children were under 6 years of age; three-fourths were under 13.
- The median number of child recipients in AFDC families was three.
- In two-thirds of the families all the children had the same father and mother.
- Over 13 percent of the mothers in the program were regularly employed; another 7 percent were enrolled, or waiting to be, in a training program.
- While the great majority of the working mothers made various kinds of child care arrangements for their preschool children, in 17.3 percent of the cases of working mothers with children 6 to 14 years of age, 9 percent with children 3 to 5, and 1.3 percent with children under 3 the data indicated "child looks after self."
- 36 percent of the mothers did not

work because they were incapacitated, had no marketable skill, or could not find suitable employment; 35.5 percent, because they were needed at home.

Costs of child-rearing

It costs nearly as much to raise a child on a Southern farm as it does in a North-Central city, according to estimates of the U.S. Department of Agriculture presented by Jean Pen-nock in the December 1970 issue of *Family Economics Review*. ("Child Rearing Costs at Two Levels of Living by Family Size.")

The article presents tables giving low-cost and moderate-cost estimates at 1969 prices for raising a child up to his 18th birthday in farm and urban areas of the two regions for two-parent families with two, three, four, and five children.

According to the low-cost estimates, the 18-year cost of raising a child for an urban family with two children in the North-Central region is \$25,560; for a farm family in the South, \$25,510; for an urban family in the South, \$24,350; and for a North-Central farm family, \$23,070. At the moderate-cost levels the figures are \$35,150 for urban North-Central, \$37,600 for South farm, \$37,990 for South urban, and \$34,010 for North-Central farm.

Taking the cost of raising a child in a three-child two-parent family as an example, the author points out that differences in costs at the two levels of living is less in expenditures of food (where it is 22 percent) than in other categories, especially housing, where the difference between the two levels is 56 percent.

Prediction in foster care

The foster parents' motivation alone bears no relation to the success or failure of a foster placement, but does play a major role in interaction with various other activities, according to Jonathan Kraus, senior research officer of the Department of Child Welfare and Social Welfare of New South Wales, Australia, writing in the January 1971 issue of *Social Work*. ("Predicting Success of Foster Placements for School-age Children.")

He describes the findings of a study, involving 157 school-age children placed in foster care in New South Wales be-

tween March 1, 1965, and March 31, 1967, to investigate the relationship of the characteristics of the children and the foster homes to the outcome of placement. Defining "success" as a 2-year stability in the placement, he reports that no relationship was found between the outcome of placement and the sex, age, and intelligence of the children; agreement of the child's sex and age with the sex and age preferred by the foster parents; or the social workers' assessment of the foster parents' ability to cope with a child with behavior problems.

Of four categories of motivation—"generally interested," "know child," "want company for own child," and "want a child"—"generally interested" was most highly associated with success while "want company for own

child" was associated with failure.

The article presents "prediction tables" showing combinations of characteristics of foster homes found to be "very successful," "moderately successful," "moderately unsuccessful," and "very unsuccessful." The "very successful" combination included: (1) foster mother 46 years of age or older; (2) two of the foster parents' own children in the home; (3) one or more other foster children in the home; (4) other than four residents, including foster child; and (5) motivation "generally interested."

The negative correlation with success of "four residents in the home," the author points out, seems to be related to the fact that in such families foster child was probably taken in company for an only child.

readers' exchange

ALLEN: Scarce couples

Spencer Allen in his letter to Readers' Exchange asks for comments on group homes in the United States. (CHILDREN, January-February 1971).

The fundamental difficulty with group homes is that there are practically no couples equipped to carry on this type of work.

The salaries are generally adequate and the living quarters are usually good. For these reasons couples try to enter this field, although they are totally unequipped to guide or counsel adolescent boys and girls. Too often these couples are so insecure themselves that they have minimum stable qualifications necessary to help children who are themselves insecure. Some of the younger couples understand adolescents but seldom combine their understanding with the amount of maturity or stability necessary for this difficult work.

On the whole, I believe three single child-care workers are often a more satisfactory arrangement than a couple and one child-care worker. It is all right

if you can get good couples. It is often as difficult, however, as finding a needle in a haystack."

Gertrude R. Stein, Inc.
New York, N.Y.

MILLAR: Appreciation

I have read with interest and appreciation, Dr. T. P. Millar's article "The Hospital and the Preschool Child," in the September-October 1970 issue of CHILDREN.

This article highlights clearly and concisely the reasons why hospitalization can, and often does, have so devastating effects on preschool children. It also has the added advantage of being short enough so that even the busiest nurse or doctor should be able to find time to read it.

In my opinion, it should be required reading for everyone working with children in a hospital setting.

Maude Bothwell
Mental Health Worker
The Montreal Children's Hospital
Montreal, Quebec, Canada

U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

ADULT RESPONSIBILITY FOR JUVENILE DETENTION CARE. John Downey. HEW, SRS, Youth Development and Delinquency Prevention Administration. 1970. 16 pp. 20 cents.

A revision of an earlier publication, this booklet stresses the importance of efficient and humane care for children in which it is necessary for detention.

PREVENTION OF IRON-DEFICIENCY ANEMIA IN INFANTS AND CHILDREN OF PRESCHOOL AGE. Samuel J. Fomon, M.D. HEW, PHS, Health Services and Mental Health Administration, Maternal and Child Health Service. 1970. 19 pp. 20 cents.

Defines iron-deficiency anemia as "the most prevalent nutritional problem among infants and children in the United States"; urges parent education for its prevention; and recommends giving elemental or medicinal iron to infants in high-risk groups and iron-fortified foods to all other infants.

HEW refers to Department of Health, Education, and Welfare; **OCD**, to Office of Child Development; **PHS**, to Public Health Service; **SRS**, to Social and Rehabilitation Service.

YOUTH AND VIOLENCE. Marvin E. Wolfgang. HEW, SRS, Youth Development and Delinquency Prevention Administration. 1970. 91 pp. 55 cents.

Presents a study of the social and psychological forces that produce violence in young people.

CARING FOR CHILDREN SERIES:

- I—The Ways Children Learn, 16 pp.
- II—More Than a Teacher, 20 pp.
- III—Preparing for Change, 24 pp.
- IV—Away From Bedlam, 20 pp.
- V—The Vulnerable Child, 20 pp. Lois B. Murphy and Ethel M. Leeper. HEW, OCD, Bureau of Head Start and Early Childhood. 1970. Single copies may be obtained from OCD.

This series of five publications is intended for use as guides for teachers and aides in Head Start and day-care centers, and for parents.

ACTION AGAINST MENTAL DEFICIENCY: the report of the President's Task Force on the mentally handicapped. September 1970. 62 pp. 35 cents.

Contains recommendations for legislative and executive action to prevent and alleviate mental handicaps in children and adults.

HEALTH MANPOWER SOURCE BOOK 21: allied health manpower supply and requirements: 1950-80. Maryland Y. Pennell and David B. Hoover. HEW, PHS, National Institutes of Health. PHS publication No. 263, Section 21. 1970. 107 pp. \$1.25.

Presents statistical information for the years 1950 through 1980 to assist in evaluating the status of and trends in training, employment, utilization, and demand for health manpower.

TOWARD A COMPREHENSIVE SERVICE DELIVERY SYSTEM: through building the community service center—a draft working paper for State and local social service agencies. HEW, SRS, Community Services Administration. 1970. 62 pp. Limited copies available from CSA.

A guide for redesigning social service systems to bring about the coordination of public and private services; built-in planning, evaluation, and resource mobilization; systematic identification of gaps in resources; specialization in service delivery; response to the consumer's request; and accountability.

photo credits

Frontispiece, Families for Interracial Adoption, Boston, Mass.

Pages 45 and 46, White House Conference on Children.

Page 51, District of Columbia Social Services Administration.

Page 56, Pacific Oaks College and Children's School, Pasadena, Calif.

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ethics in intervention research
thinking skills as a group work goal
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Making it downstairs in an upright position is one of the major accomplishments of early childhood, as this toddler's concentration on the task suggests. A participant in an "early intervention" program to simulate various aspects of development, the child is photographed during a test of his motor skills and coordination. On the next page another child in the same program is learning from his father how to hold a cup by the handle. Some thoughts on the ethical considerations in intervention research are offered in the accompanying article.

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ETHICAL ISSUES in RESEARCH in EARLY CHILDHOOD INTERVENTION

SUSAN W. GRAY

In a sense this paper represents an extension of an article by M. Brewster Smith about value conflicts in behavioral research with children that appeared in *CHILDREN* 3 years ago,¹ since its purpose is to examine the ethical issues involved in research on the effects of planned intervention early in a child's life. In another sense, however, I am presenting here a somewhat personal account of over a decade of involvement in intervention research with young children from low-income families. In the past decade my colleagues and I have moved from a time in which intervention research on low-income children was seen as a somewhat aberrant interest for psychologists through a time in which we were seen as in the forefront of a brave new social movement, to a time in which the desirability of our work is seriously questioned in some quarters. The wide attention given to the Jensen article in the *Harvard Educational Review*² and the Westinghouse report, "The Impact of Project Head Start,"³ is indicative of the public's interest in programs of intervention as well as of some feelings of disillusionment.

My own first contact with the field of intervention research was a brief one in the summer of 1959. Several of us at Peabody College for Teachers who were concerned with school psychology planned a summer kindergarten experience for black children from low-income families to be given just prior to their entrance to the first grade of school. In a sense

our approach was not casual. We carefully reviewed the relevant literature on social class and on child development; we planned the children's experiences in the program in great detail; we carefully selected as lead teacher a black woman who was an exceptionally gifted first grade teacher. But we failed to question the general appropriateness of the study or to consider the possible harm our intervention might do to the child or his family.

Within the next 2 years Rupert Klaus and I began a much more extended study, the Early Training Project,⁴ which required us to face up to these questions and to many more. It involved intensive work with young children in the two or three summers prior to their school entrance. Included as a bridge from one summer to the next was a series of weekly visits to the home during the year.

As we began the study, I consulted two of my wisest and most experienced colleagues in regard to ethical considerations. Fearing that our avowed goal of changing the children's attitudes towards school and school-type activities might create a distance between the two generations, we planned to spend a large proportion of our time working with parents, helping them understand what we were doing and encouraging them to take part in the process. Still we were concerned about whether we were engaged in a bit of middle-class brainwashing.

Our social-psychologist colleague assured us that, with the particular technique we were using, we had

little need to worry. He thought it unlikely that the study would result in any profound attitude change. Experience has taught most social psychologists that changing values and attitudes is an extremely difficult thing to do.

To our clinical-psychologist colleague we posed the question: Were we making these children dissatisfied with their own lot in life? At that time the small town in which they lived had few opportunities for black people to move upward. He replied that our project was an act of our faith that the future would hold more opportunities for these children than had been available to such children in the past.

Thus reassured, we began the Early Training Project. But in conducting the study, we carefully tried to avoid any negative effects of the kind that had been worrying us.

In the decade since the beginning of the Early Training Project my colleagues and I have in one way or another identified many of the ethical issues that impinge on educational and psychological research in this area. We have talked about these issues with the workers who are in direct contact with the mothers and children in our studies, with others working in intervention research, and with persons engaged in other types of behavioral research. In discussing the issues here, I will also present some thoughts about research on human subjects in general drawn from the deliberations of the American Psychological Association Committee on Ethics in Research with Human Subjects.⁵

Intervention research, however, imposes some special characteristics of its own. It is necessarily longitudinal—that is, it takes place over a considerable period of time. Typically many changes, some intentional and others not, are introduced into the system—the child and his world. The objectives are apt to relate to motivational characteristics and also to various facets of intellectual competence. Thus, the

program may touch not only the persons who are its specific targets but also those with whom they live and associate. The effects are intended to be lasting and substantial. Inevitably, much intervention research has a fairly strong service orientation and thus runs into the demands and expectancies of direct service programs. Finally, because intervention research touches many social and educational concerns, it is a highly sensitive area.

Questions and criticisms

A decade ago developmental “interveners” were seldom questioned about their motives and general intentions. It was usually taken for granted that a program that had clear implications for human welfare originated from positive motives. Today questions arise, particularly from members of minority groups, concerning such motivation. The majority of these questions have little to do with methods of research, but rather with intervention as such, whether in a service or a research program. Nevertheless, intervention researchers must take these questions into account.

Some objections center on the rights of parents. There is certainly no question from the legal standpoint that the parent is completely responsible for the child and has a full right to grant or withhold consent for the preschool child's participation in a program—up to a point. This point may be reached in extreme cases of a medical need, as when a parent refuses a transfusion or an immunization in the face of clearcut danger to the child's life. The more difficult question perhaps is whether the parents' rights extend to decision-making with respect to the intervention program itself and include the right to dictate the program's methods and goals. This is not an easy issue to resolve. I shall return to it further.

Other questions go beyond the parents' rights. One criticism leveled at developmental interveners these days is often put this way: How do you dare to work simply with young children when the basic problem is the entire social system?

This question, of course, implies a certain lack of distinction between a child development worker's professional role and his civic role. Asking a developmental intervener to work to change the whole social system is about as inappropriate as asking a thoracic surgeon why he does not give up the practice of lung surgery and instead work on outlawing cigarettes and certain pollutants in the atmosphere. The answer must be that it is highly appropriate.

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the professional person to engage in social action in his role as a citizen, but to expect him to devote his entire time to such efforts ignores the ethical imperative for using most productively his particular competence in promoting human welfare.

The preliminary report of the APA Committee on Ethics in Research with Human Subjects states: "We began with the commitment that the scientist's distinctive and most effective contribution to human welfare is intelligent application of his scientific knowledge and skills. His underlying ethical imperative, thus, is to carry forward his research as well as he knows how."⁵

In his civic role the citizen-scientist can appropriately work to change the social system or environment that has created some of the problems to which his research addresses itself. In his scientific role, his first concern ethically should be to carry on his research to the best of his ability.

Of class and culture

Another broad issue that comes under general questioning by the public today has to do with the goals and values of the intervener. The issue typically is brought up by members of minority groups—persons who see themselves as spokesmen for minority groups. Many of their questions are highly relevant. The usual accusation is that interveners are promoting a white middle-class model of what is appropriate behavior when dealing with other ethnic groups. Obviously, intervention programs can confound, or can be perceived as confounding, elements of social class and race, for the representation of minority groups—especially the black, the Spanish-speaking, and the American Indian—in the low-income segment of the population is disproportionately high.

Developmental interveners are often accused of working with a theoretical model based on an assumption of deficiency in the subject.^{6, 7} In theory we can speak about cultural differences; in practice many of us are concerned with cultural deficiencies. Today these terms are laden with emotion and provoke bitter criticism. In a sense the accusation is just.

There are two ways, however, to look at cultural deficiencies. One is to take the view that a given culture simply tends to be deficient; some cultures are better—presumably in God's eyes—than others. Few social or behavioral scientists would defend such a stand. The other view, a broader one, emphasizes cultural differences among segments of our society but



Using a story of a fox stealing chickens, a staff member in the Demonstration and Research Center for Early Education at Peabody College helps a little boy learn to subtract.

looks at and attempts to remedy the "deficiencies" of a given subculture in relation to a specific societal demand. If we accept the point of view that the technological civilization of the 1970's rewards the person who can read more than the person who cannot read, then we have a case for intervening to correct a specific deficiency—if a person wishes to take advantage of these rewards. Some subcultures have child-rearing practices that make learning to read more of a problem for their children than it is for children generally. Helen Bee has presented a thoughtful analysis of this point of view.⁸

The issue of cultural differences versus cultural deficiencies is, of course, confounded with the failure to distinguish the differences in social class. A few years ago a great deal of professional attention was being directed towards the concept of a "culture of poverty." Those who espouse this concept believe that patterns of coping develop in extreme poverty and that certain of these patterns are institutionalized—that is, they are adaptive to living in poverty but may be maladaptive to moving out of poverty. The

late Oscar Lewis^{9, 10} was a leading spokesman for this point of view.

Certainly the shum, today often called "the ghetto," is not a new phenomenon. The passing of a predominantly rural society has always brought in its wake the urban slum. One has only to read about the 19th century slums of London in one of Charles Dickens' novels or what Maria Montessori had to say about the slums of Rome early in this century¹¹ to see that there is nothing new about the debasing of human life in city areas where the poor are congregated.

The confounding of social class differences with true cultural differences has led to problems in planning intervention programs and in observers' interpretations of these programs. How we resolve these problems is probably going to depend in part upon our view of how we should deal with cultural differences.

We could follow the old American philosophy of a melting pot society. Today, however, many minority groups are becoming less and less willing to be

melted down. We could ignore cultural differences—a rather unsatisfactory approach since it does not work. We could use cultural differences to build a bridge for meeting the demands of the larger society.

This last approach is the one used by many of the more carefully planned intervention programs. The child is taken "where he is." His first reading materials, for example, are based upon experiences that are familiar to him. So far so good; most interventions would "buy" this in relation to certain skills and areas of understanding that are regarded as necessary for a person to have in our ever-contracting globe. The problem is how far interveners should go in this direction.

The more thoughtful intervention programs today, as well as the general trends in our society, seem to reflect a move toward a degree of "cultural pluralism." Ideally, under cultural pluralism many different groups live in the same society with mutual respect, and mobility from group to group is possible not only over an extended period of time but also immediately.

I have found that many of those who cry separatism in this country do not really mean complete separation; when they are pinned down, it turns out that they mean cultural pluralism. Separatists wish to take advantage of the rewards of the larger society which clearly makes unfair demands on minority groups. But even the separatists do not sentimentalize the life of poverty. It is hard to find anything edifying about cockroaches or ethnically valuable about hunger and disease.

The United States seems to be one of the few countries left in the world where a degree of cultural pluralism is not taken for granted. In few countries, for example, is bilingualism such an issue as it is here. In many countries today it is taken as a matter of course.

Widening options

My suggestion for resolving these issues is certainly not unique, but it is one with which I can live. It is that an appropriate goal in intervention programs is to make possible more options for the individual in his childhood and in adulthood.

One of the most characteristic aspects of poverty is that the poor have no options. The extremely poor must live hand to mouth, day by day, because they are at the mercy of external circumstances; they cannot take advantage of opportunities nor can they plan ahead. In a very different way, certain cultural

A teacher in an early intervention program shows a mother how to encourage her child to play with educational toys.



end to restrict individual experiences regardless of socio-economic class. Take, for example, the Amish. In the view of the "old order" Amish, education should be simply teaching the child to read well enough to read the Bible and to cipher well enough to figure simple quantities on the farm. There is some evidence¹² that Amish children experience adjustment problems in school because of the discrepancies between the schools' and their families' values. The way of life of the old order Amish has much to recommend it, but many people would question a view of education that systematically limits the options for the coming generation.

A society that maximizes options may be one having a degree of cultural pluralism but enough commonality in the education of the young to make a range of choices available to all. This approach should not be regarded as based on a belief that the schools and society are always right or that early childhood intervention alone can resolve their problems. Clearly, throughout society, including the schools, many changes are needed to widen the options for young people. The research intervener, however, may appropriately make his scientific contribution by developing knowledge that can be used to improve the ability of young children and their parents to take advantage of these options as they become available or to open up more options themselves.

The American Psychological Association Code of ethics¹³ is currently under revision, with particular attention being paid to a section on research on human subjects. A tentative draft of the introduction to this section,⁵ read at the APA meeting last year, dealt with the ethical dilemmas the psychologist faces and suggested as a possible approach a weighing of risk versus benefit. This suggestion should be helpful to those of us who plan to conduct intervention research. But there are difficulties.

As I have already pointed out, intervention research refers to systematic attempts over an extended period of time to make some substantial and lasting changes in the functioning of an immature organism. The nature of the hoped-for changes and the extended period of the intervention make the weighing of risk versus benefit an exceedingly complex judgment, albeit one that must be reached before the research is embarked upon. As the APA report emphasizes, if risk and benefit are in exact balance there is only one ethical decision: to count the risk as more important than the benefit. Unless we can clearly demonstrate that the possibility of benefit from the research is greater than the risk involved, we should

not proceed. In the words of the APA report we must maintain "an insistence that the human subject emerge from the experience unharmed and, if possible, with an identifiable personal gain."

Specific principles

Let us look now at some specific ethical principles.

Paramount among these is the importance of remembering that in intervention research *you can't do just one thing*. In attempting to make relatively large and enduring changes in a child and his world, we generally take as the point of entry the child himself, although we may take the mother and child together. However, no matter what the point of entry, when one is trying to make profound changes in a system, one must work with due regard to all the aspects of that system, including the relationships involved. Furthermore, one cannot ethically terminate an intervention program without making whatever provision possible for some type of continuation or sustaining treatment. Herein lies the reason for the increasing emphasis in intervention programs on work with parents and for the establishment of Follow Through programs to pick up in the first grade where Head Start leaves off.

Another principle is the avoidance of the invasion of privacy. This is a particularly tender area for developmental interveners who work with children and their parents in their homes, as we do in our research at Peabody. I have often talked over this issue of privacy with the supervisors of our home visitors. I remember one of them saying that the most important thing for the home visitor to learn is just where the privacy line is, and that this is particularly difficult because the line is different in every home. What one family regards as intrusion may be interpreted simply as friendly interest by another family. A person can easily learn not to pry; it is not so easy to identify the line between intrusion and an appropriate interest in the concerns of the person with whom one is working.

Another problem associated with the invasion of privacy is that work with young children and parents from poverty-stricken homes is good newspaper copy. A nice dilemma is posed when one's long-term goal is to improve the lot of the poor. More public attention to the needs of low-income groups may in time have a positive effect in changing public opinion toward them. But it is difficult to provide public recognition of the needs of the poor without some invasion of privacy, particularly by local news



Encouraged by the warmth of a one-to-one relationship with her teacher, this little girl is learning to count by using an abacus, which was out of the camera's range.

sources. Our solution, not always successful, has been to avoid all publicity until a study has been completed. We have, however, felt an obligation to communicate findings that might be helpful to others, always avoiding the release of any identifying data. It is not always possible, however, to avoid premature publicity. The only solution we have found is to work with reporters of local newspapers and TV stations to try to help them understand why it is important to withhold publicity at a particular time.

Another important ethical principle—one not always honored—is to show respect for the dignity of the individual, whether a little child or an adult. This seems obvious. But persons with a strong middle-class bias are not always able to respect persons whose ways are different from their own. It is not always easy for an inexperienced, middle-class

worker to hide an aversion to clutter or to conceal annoyance over complete apathy in the face of a solvable problem. Consequently, a research director must exercise extreme caution in selecting staff members, to be sure that they can show true respect.

A closely related principle is to avoid exploiting research subjects, or even the appearance of exploitation. Whether the exploitation is fancied or real, the feeling of being exploited arouses great resentment among residents of black ghettos and other low-income areas. It goes without saying that genuine exploitation is unethical. What often happens, however, is a result of thoughtlessness—a fascination with a problem causes the researcher to rush in too quickly, without carefully weighing the possible consequences. Spokesmen for minority groups can hardly be blamed if they sometimes feel that behavioral researchers act as though they had discovered a new experimental animal.

Perhaps the best way out of this danger is to take careful counsel with the persons who will be involved in the research. Brewster Smith¹ suggests that when one's "subjects" research workers adopt a genuine collaborative attitude.

Some difficulties

A well-known ethical principle requires that "informed consent" be obtained from the child's parents and from the child himself if old enough to understand. This principle originated in medical research and is clearly appropriate in medical practice.¹⁴ It may not seem so applicable in nonmedical types of intervention. The possible harm engendered by such intervention is not great compared with possible gains, and the effects are reversible if detected during the program. Still this difference does not save us from risk versus benefit accounting. The developmental intervener, however, has a problem in following the principle of informed consent.

Much of our research is carried on with children who are far too young to understand. The answer, say, is to inform and get counsel from the parent, which we usually mean the mother. Well and good, but how can one really inform the parent if the parent has very limited understanding of the principles of child development? Still, one must try to give the parent as great an understanding of the goals and methods of the program as possible. If the principle of informed consent were applied literally, however, most intervention research would have to cease.

My own answer to the dilemma of informed consent is this: intervention researchers should inform the mother as best they can and then should work with her over a period of time to make more options available to her in her interactions with her child. Of greatest importance, perhaps, are efforts to help the mother increase her understanding of and competence in carrying out the acts that will be instrumental in achieving her own goals for the child.

Thus, informed consent in intervention research involves a collaborative approach. It also involves another principle: one must be very careful not to raise false hopes. The best guide is complete honesty with the parent.

Another ethical dilemma facing the developmental intervener derives from the discrepancies in the values between generations. We know next to nothing of the future of the infants with whom we work. Margaret Mead made this excellent point some years ago.¹⁵ Since the future is largely unknown, the major emphasis of an educational program for any human being might well be placed on the development of the qualities and characteristics that make learning possible. Perhaps the only thing we know about life 10 years from now is that the competencies required of people will be different from those required today. Stable societies, such as the Amish, provide clear illustrations of the dilemma facing today's educational planners. I wonder if those who advocate cultural separatism, or even cultural pluralism, may not have some difficulty with this issue. They may face a question similar to the one raised in the World War I song, "How Ya Gonna Keep 'Em down on the Farm After They've Seen Paree?"

Shall we opt for the current generation of whose values and wishes we have evidence, or shall we opt for the generation of the infants and the small children? To cloud the problem further, major shifts in values are no longer a matter of generations 20 to 30 years apart, but occur even in 5-year spans.

There is, of course, no answer. The legal right is clearly with the parent, but where is the ethical responsibility of the intervener? Perhaps a partial answer lies in our efforts to interpret for the older generation the meaning of rapid change and to try to bring parents along as collaborators in building the kinds of skill and motivation in their children that will allow those children to choose among the opportunities that may be ahead in an unknown future.

Thus, there are only a few guides and many dilemmas in facing the ethical questions involved in

developmental intervention. Each person has to make his own judgment as carefully as he can.

Most universities have established the kind of ethics committees advocated by the United States Public Health Service: committees of colleagues to evaluate proposed research plans from the standpoint of the ethical issues involved.¹ Without such a mechanism for outside review, there is danger that the researcher's own bias may sway his judgment.

Unfortunately, however, such committees are seldom able to understand the complexities of the issues involved in a particular mode of developmental intervention. Perhaps what is needed is a kind of collegial review by fellow developmental interveners. Yet in the last analysis each person who conducts an intervention study must face the difficult, demanding, and lonely task of determining his own stand on the ethical issues inherent in trying to make lasting changes in young human beings.

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thinking skills as a goal in an after-school program

ROBERT SUNLE

● Every Monday and Thursday afternoon after school 12 first- and second-grade boys and girls in a predominantly black, low-income community in Freeport, N.Y., come to play at the Family Community Center operated by the Family Service Association of Nassau County. At first glance one might have the impression that they are participating in a typical group work program. Despite some noise and confusion, they are presumably learning about taking turns, cooperating, following rules, and listening—somewhat—to the adult leader.

However, more careful observation would indicate that there is a difference. Take the way the children engage in a relay race: Each child in turn runs to a table at the end of the room, pauses to select a button and drop it into one of three cans, and runs back to his team. On the table is an assortment of buttons of three sizes and many colors. The leader calls out, "In the next race, put a small red button in the middle-sized can."

An ordinary relay race has been transformed—to what end? Further observation shows changes in other familiar games and activities—playing tag, making collages and scrapbooks, storytelling, and drawing. The supervisor, Elaine Perkins, explains to the observer, "The children come to have fun. We don't spoil that, but we build in something extra to help them with basic concepts that most of them haven't mastered."

These children, like a great number of others from

low-income families in this country, are labeled "disadvantaged" or "culturally deprived." Nearly all suffer some specific cognitive deficits. They lag behind in the development of "thinking skills" facility and clarity in visual and auditory discrimination, labeling, comparison and classification, ordering, categorization, and so forth. By the time they start to school, their innate capacities to perform the rudiments of thinking are seriously underdeveloped. They suffer severely as their classmates progress through abstract and complex material. Many lose interest in school, closing their ears and becoming antagonistic. Massive, long-term remedial efforts are then required to reverse such a handicap, even partly.

All the activities these children engage in at the community center are part of a Thinking Skills Program designed to develop and sharpen their cognitive skills. Each fall almost all the children from 5 to 9 in a housing development and surrounding area register for this after-school program; newcomers are accepted throughout the year. The program now has nine groups, each composed of kindergarten, first-, second-, or third-grade children that meet twice a week. Each group is assigned a Youth Service Project staff member experienced in social work or education and at least one student assistant.

The Thinking Skills Program was conceived at the Family Service Association's Youth Service Project in 1964 as a new element in its group work

for children. Andrew Eklund, then senior caseworker of the Youth Service Project, suggested that a special approach be used with first-grade children in the group work program. He pointed out that there are stages in the process of thinking conceptually that can be utilized in working with a group.

As the staff members formulated the new program, a basic question arose: Shouldn't efforts toward cognitive development be left to the schools as a responsibility logically falling within the province of education rather than within the province of social work?

Two answers affirmed the role of social work:

1. Thinking skills are not necessarily directly related to school curricula; a child needs various non-academic types of experiences to foster the development of the thinking processes that he will need as an adult to function adequately in a complex urban society.

2. Thinking skills could be incorporated into the agency's group work program already under way. At the time the program began, schools were paying little or no attention to the area of cognitive development. Later, we learned that an evaluation of Head Start type preschool programs showed "... conclusively that early compensatory education is of very limited, short-term benefit unless there is consistent followup."² The evaluation found that spectacular gains made by children in such programs were quick to erode in the first 4 years of school unless they were constantly reinforced.

The staff envisioned the Thinking Skills Program as a valuable followup of early intervention programs for children with several inherent advantages over school-based efforts:

- The children would come voluntarily for fun; therefore, they would be receptive to the program.
- The children would be associated with others at the same general developmental level, from their neighborhood peer group, thus minimizing feelings of inferiority and failure.
- The development of group cohesiveness and morale would encourage the children to act as motivators and reinforcers instead of relying on the leadership of an adult.
- Programs could be tailored to each small group, with no need to become standardized.

The practical application of the thinking skills idea was difficult. While confronted with the day-to-day problems of conducting a group program for children, the leaders had to experiment with new methods and attitudes. The program director and the supervisor had to grope their way among theories while trying to give specific direction to the leaders.

To date, the Thinking Skills Program has served more than 200 children. Its concepts have been adapted for use with groups of older children and in the Association's summer day camp.

Program emphases

Seven major aspects of learning theory have been taken into account in the program. The following paragraphs describe the theoretical background and how it has been translated into activities.

Sequence and transferability. The literature on learning emphasizes the importance of introducing planned experiences to children in a logical sequence and of proceeding in very gradual steps.^{3, 4} The requirements for learning would not be met if children were exposed to many essentially unrelated experiences of various levels of complexity.

Transferability refers to the ability to adapt a concept that is applicable in one context to other somewhat different contexts. For example, a child learning the concept of *relative sizes* must be able to transfer a comparison of three cubes to a comparison of three different kinds of animals to a comparison of remembered objects. Children master transferability and other mental capabilities at different rates; their abilities do not develop in a straightforward logical progression as adults tend to assume.⁵

In the Thinking Skills Program, the importance of sequential learning is taken into account by providing connections between activities within a session and from session to session. Sometimes a related

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Boys in the Thinking Skills Program learn about time by making clocks and reviewing sequential pictures with one of the program's group leaders.

theme or area of interest is sustained through many sessions. Leaders adjust the sequence of individual activities, the emphasis on transferability, and the small transitional steps in concept development largely through trial and error. After observing the times that children show uncertainty, vagueness, or achievement, the leaders review the structure of a game or other activity to simplify it or to introduce additional steps.

Transferability is emphasized by eliciting an idea from the children, by pointing out other applications of it in their daily lives, and by reviewing the steps they took to arrive at their conclusions. A leader may gradually increase the complexity of a relay race, for example, to give the children practice in discriminating between essential and extraneous elements.

Language development. Language plays a highly important role in a child's cognitive development, although its exact relationship has not been established.^{6, 7} The ability to communicate in oral and written language is an invaluable asset in school as well as in adult life. In the Thinking Skills Program, emphasis has been placed on sharpening the child's

ability to receive and understand communication from others and to express himself verbally.

The leaders follow a staff-written guide that relates various aspects of the English language to the concepts emphasized in the program. For example, the guide points out that the general concept of *classification* (involving comparison) is embodied in the selection of nouns that go together, and that sequence of events is expressed through verb tenses and qualifying adverbs and clauses. In teaching the concept of *before and after* to disadvantaged children, the leaders make use of the time sequences that arise in a child's spontaneous telling about what happened on trips or at home. The development of the concept of *we* is fostered through games of identification, such as the one in which children call out the names of group members.

Correlation of motor activity with early steps in cognitive development. A child makes a very gradual transition from merely handling an object, to developing language and mental images as he handles it, to developing mental images that do not depend on the presence of the object. The motoric accompaniment appears to be necessary until cognitive development is fairly far advanced.⁶ In most thinking skills sessions, motor activity is built into games, arts and crafts, and other play. The leaders encourage the children to talk about their physical activities and so take the mental steps necessary for cognitive development. For example, in the relay race the child makes progress from selecting a button to telling another child how to select the "right" button. As he reviews the activity involved in selection, he is taking a step toward symbolic thinking.

The program emphasizes objects familiar to the child in his daily environment. It introduces new experiences gradually, limiting the variety of stimuli to those the child may be able to absorb at one time. By preparing the child to apply what he has learned within his own environment, the learning experience is likely to become reinforced through frequent application.

Activities without failure. The child with a cognitive handicap is particularly vulnerable in situations where there is a clear-cut standard of success and failure.⁸ Therefore, to counteract the disadvantaged child's already existing feeling of inadequacy, the program avoids individual competition and group activities in which many children fail, and other activities that inevitably favor the same few

children who know the "right" answer. Instead, the leaders ask individual children questions tailored to the child's specific experiences, and select games that emphasize intergroup competitions.

Developmental level. Initial assessments of the level of conceptual development of each child and of the group as a whole provide a basis for gearing the program to the children's needs. In part, these assessments are made through simple tests in which children respond to questions of reasoning—such as dividing a list of items into categories of "same" or "different." In part, each group leader uses program activities to discern the children's developmental level.

The children in each group represent a fairly wide range of development. At the end of the first year the staff found that the Thinking Skills Program had helped children who initially rated high in conceptual development, but it had had little impact on the children who rated low. In the second year when the emphasis of the program was shifted to simple comparisons, children with initially low ratings made definite gains.

Structure of participation. Many types of activities are used to achieve program balance, including both active and quiet games and other activities that permit individual participation or expression by the children. Some games involve taking turns, one at a time; some involve taking turns in pairs; some are "all at once" games; some involve eliminations. Games that require long waits for most of the children have been eliminated, however, because such games not only foster inattention and misbehavior but also severely limit the amount of time any one child gets to practice the conceptual tasks involved.

Arts and crafts provide opportunities for individual expression and trips introduce new experiences. The variety is compatible with attempts to make the program fun, thus distinguishing it from school-type programs that tend to be repetitive, sedentary, and nonparticipatory.

Group behavior. The aims of any group program can be negated by inattention and disruptive behavior. The Thinking Skills Program leaders have followed two models in handling disruptive group behavior. The therapeutic model calls for the development of a positive relationship between the leader and each child, and for discussions of the feelings behind the child's behavior. The behaviorist model

uses both positive and negative reinforcements. For example, the leader initially may ask the children to sit quietly at the table; he serves snacks only after they have followed his directions. He continues to work with the group members until they do not need a reward to sit still for a long discussion.

To understand the children's behavior, the leaders use assistants' observations of individual children, as well as knowledge of each child's home situation in relation to its possible effects on his behavior from week to week.

When, for example, James, age 7, came in to the center one afternoon with a sullen expression, the assistant alerted the leader for trouble. Soon it began. James teased and wrestled with the other children, but would not talk to the adults. Later, the leader visited James' home and learned that his mother had been rushed to the hospital. In the next session James was encouraged to talk about his anxieties instead of acting them out.

Leaders also try to develop a favorable group attitude toward the development of cognitive skills. This emphasis is particularly important in low-income areas, where children's peer groups seem more influential than parents or school.

Planning and implementation

In the first year, plans for group activities were drawn up by the leaders, reviewed by the supervisor and director, and then followed fairly consistently. This method proved to be too rigid. Therefore, in the second year, the leaders were given more latitude in selecting activities within a planned sequence of sessions that maintained an emphasis on the concept of *size*. But again, the planning provided too rigid. Since then, the agency has developed a repertoire of successful activities from which the leaders can make selections for a balanced program. Furthermore, such a repertoire gives a leader the flexibility to modify a plan on the spot, if necessary.

The following brief descriptions of specific program activities show how games have been modified to accentuate the ideas being emphasized.

A planned series. A series of eight sessions was projected near the beginning of the year to teach a group of first graders several new concepts. At the first session the children played color basket upset, a modification of fruit basket upset that uses colors as well as names of fruits. Session II introduced the concepts of *big* and *little* in the game. A relay

race was also staged at this session, with the children divided into teams; the emphasis was on rules and structure since relay racing was new to most of the children. The fourth session introduced the concept of *middle size* into the fruit basket upset game and the selection between two colored objects into the relay race.

The relay race was repeated in later sessions and a third object was added, giving the children a choice between big, middle-sized, and small objects. In all the sessions the leaders used picture books, such as "Let's Find Out What's Big and What's Small" and "The Three Bears."

These sessions were moderately successful. Some leaders said, however, that changes were introduced too rapidly and that most of the children needed more repetition of the concept of *middle size* earlier in the series.

Group identity. The use of a picture puzzle that included the name of each child in the group helped in building a sense of group identity—that is, in developing a sense of "we" in relation to "I"—and in setting a tone of purposiveness for the group activities. One of the puzzles, for example, took the form of a clown with a child's name written on each piece. One leader has described how she used this activity:

Then I brought them over to the new puzzle. William grabbed his piece at once and began to look for its corresponding shape. He couldn't find it. Then James found it for him. I asked the others to find their pieces and they did. Each of them worked with the others to find the place for the piece. I did not interfere. When four pieces were in, I asked if they knew from looking at the partly finished puzzle what it would be. Tommy said a clown.

We went from piece to piece, calling out the person's name and then finding the right spot for the piece. With each name I asked if the child had been seen today, and we found out this way who was absent. Then we looked at the finished product and Susan said Tommy had guessed right.

Color tag. One leader devised the game of color tag because many of the first graders did not know the names of colors. He taped colored squares of paper to the floor of the meeting room and all the children except the one who was "it" had to stand on a designated color to be "safe." The game progressed to the use of two different colors for "safe," with the children naming the colors for each new game

inars. By helping give tests to the children before and after participation in a group, the group leaders discovered for themselves some of the children's deficiencies. The leaders receive continuing supervision, part of which is focused on the problems of individual children. They also make occasional home visits.

Evaluations of the program have been made each year, although the focus of the Youth Services Project has necessarily been on service rather than research. In the second year, children were assigned to either an experimental group or a comparison group. Each group had the same number of children who made high, medium, and low scores. Throughout the year, the children in the comparison group participated in a regular group work program that did not emphasize thinking skills. The results of the post-tests indicated that the experimental group showed statistically significant gains over the comparison group. In the following years ratings by leaders and public school teachers and other methods of evaluation have indicated that the program has definitely helped the children, although it has not succeeded in eradicating their cognitive handicaps.

The emphasis on thinking skills has applicability in many other group programs for children—in settlement houses, neighborhood centers, day camps, and other settings. The program does not require either special equipment or costly materials. Groups can be led by paraprofessional or professionally trained social workers. Staff orientation and continuing supervision are necessary, however, for an effective program.

¹ John, V. P.: The intellectual development of slum children: some preliminary findings. *American Journal of Orthopsychiatry*, October 1963.

² Hechinger, F. M.: Head Start to where? *Saturday Review*, December 18, 1965.

³ Fowler, William: The design of early developmental learning programs for disadvantaged children. Supplement to *Information Retrieval Center for the Disadvantaged Bulletin* vol. III, No. 10. 1967.

⁴ Hess, Robert D.; Shipman, Virginia: Early blocks to child learning. *Children*, September–October 1965.

⁵ Szeminska, Aline: The evaluation of thought: some applications of research findings to educational practice. In *European research in cognitive development*, Society for Research in Child Development Monograph vol. 30, No. 2. 1965.

⁶ Bruner, J. S., et al: Studies in cognitive growth. John Wiley Sons, Inc., New York, N.Y. 1966.

⁷ Deutsch, M.: The disadvantaged child and the learning process: Education in depressed areas. (A. H. Passow, ed.) Teachers College Press, New York, N.Y. 1963.

⁸ Mussen, P. H.; Conger, J. J.; Kagan, J.: Child development and personality. Harper and Row, New York, N.Y. 1969.

Orientation of the agency's staff to the Thinking Skills Program has been conducted through sem-

SOME THOUGHTS ON PLANNING HEALTH CARE FOR CHILDREN AND YOUTH

HELEN M. WALLACE



High among the priorities for action recommended by both the 1970 White House Conference on Children¹ and the Joint Commission on the Mental Health for Children² is a nationwide network of comprehensive health services for children and young people. Comprehensive health services to provide children with "care and treatment through facilities which are appropriate to their needs" are necessary, according to the Joint Commission, to assure children's rights: to be wanted, to be born healthy, to live in a healthy environment, to satisfy basic needs, to have continuous loving care, and to acquire the ability to cope effectively in our society. Such services, in short, take a broad view of the whole child in his environment and are concerned as much with prevention of ill health as they are with effective early treatment.

In recommending a national program of comprehensive health services, one of the White House Conference forums on health stressed the necessity not only of developing new delivery systems but also building on our existing strengths.³ What then are these strengths and how far do they go toward meeting the need?

Aside from the few private ventures in prepaid group medical practice, some union health plans, and an unknown number of centers for handicapped children, most of the experiments in the delivery of

comprehensive services for children have probably been developed under the stimulus of Federal aid or direct Federal support, the most comprehensive of them within the past decade. They include the 59 children and youth (C and Y) projects, through which health departments, teaching hospitals, or universities provide medical, dental, social, and other services for children in defined low-income areas on a continuing basis from birth to age 19;^{4, 5} the 53 maternity and infant care (M and I) projects for high risk mothers and infants up to the age of 1 year; the 54 State crippled children's services; the 21 university-affiliated centers and 200 community clinics for mentally retarded children; the health components of 1,600 Head Start programs for preschool children;⁶ and the 55 neighborhood health centers operated by community action programs in low-income areas.

In spite of this variety of programs, comprehensive health services are the exception rather than the rule. None of these Federally aided programs reaches more than a small fraction of the children in the category for which they were intended. There are, for example, about 80,500,000 children and young people under 21 in the United States, about 16,100,000 of whom live in low-income areas. Of these, only about 11½ million were registered in 1970 with one of the Federally aided services providing comprehensive care: 434,300



A physician with a young patient and her mother at a pediatric center in a low-income area of Baltimore established to provide comprehensive health care to children and youth.

with C and Y projects; 45,000 with M and I projects; 450,000 with State crippled children's services; 5,250 with university-affiliated centers for the mentally retarded; 53,000 with community clinics for the mentally retarded; 471,600 with Head Start (262,900 in full year programs and 208,700 in summer programs); and 180,000 with neighborhood health centers.

Little is known about the kind of health care the 14,500,000 other children from families of low or marginal income receive. Many thousands, of course, receive medical care from private physicians or hospital outpatient or emergency clinics, much of it paid for by the Federal-State program of Medicaid. But it is not a mere guess to suggest that most children of low-income families—and many others too—receive only episodic care, with none of the preventive and followup services implied in comprehensive care.

Clearly, comprehensive planning is needed to assure that all children and youth will have easy access to comprehensive health care. Two possibilities suggest alternative ways for bringing this about: (1) the revision of Federal legislation and provision of funds to allow extension of the present maternity and infant care projects, children and youth projects, special services and centers for handicapped children, neighborhood health centers, Head Start health services, and perhaps, the services to be established under the new Health Start program (see p. 112); and (2) a clearer identification of the effective components of these and other group practice programs, which

should then be applied, through coordinated planning or one direct service, to all children and youth or, at least, to all who are indigent or medically indigent or who have serious health problems.

Extending coverage to all children or to all children needing it would require eliminating restrictions on services based on geographic boundaries within a community. Rather, planning would provide for a network of interrelated services covering the entire community through a system of district services linked to a chain of neighborhood services.

At the neighborhood level, physicians in private practice would be invited to participate in the organized comprehensive health care programs. This could be done—and already has been done in some children and youth projects—by offering physicians who are practicing in low-income areas private office space or part-time or full-time positions and inviting them to participate in the service's staff conference reviews of the needs of individual families, inservice training programs for staff, and other education activities. In any event, there needs to be a better tie-in between physicians in private practice and community services. And all physicians serving children need to have a hospital affiliation.

There also needs to be a better tie-in between State crippled children's services and local community planning for handicapped children—especially in large cities—in the interest of better case-finding, followup, and provision of social and recreation services.

To insure both quality and accessibility, comprehensive services are usually conceived of as involving three levels of health care: *primary care* at the point of entry; *intermediate care* for seriously ill children; and *advanced specialty care* for children with complicated problems.

These characteristics of comprehensiveness are provided for by C and Y projects in various ways. For example, in one large city, where service coverage has been broadened through the combined efforts of the local health department and the two C and Y projects in the community, the three interrelated levels of care include:

Level one, consisting of the health department neighborhood well-child conferences greatly improved by the provision of closer pediatric supervision; the addition of social workers, nutritionists and health educators; the provision of basic laboratory diagnostic services; the addition of a program screening infants and young children for commun-

ation problems; and the addition of treatment services for minor illnesses.

Level two, consisting of the seven C and Y satellite centers, with a total registration of 50,000 children, taffed to provide more sophisticated diagnostic and treatment services for ambulatory patients. Each of these centers is tied to a medical school or teaching hospital, which provides the key medical staff and in-hospital care when needed, and each serves as the place of referral for infants and children from several well-child conferences.

Level three, consisting of the participating medical schools and some teaching hospitals, includes the provision of highly sophisticated diagnostic and treatment services for children referred from the satellite centers.

Thus, by this agreement, existing health services are being improved; intermediate services of a more comprehensive nature are located close to the people who are to be served; the most highly developed services with the most highly skilled personnel are reserved for children and adolescents with special problems; and more children and adolescents are being provided with preventive, diagnostic, and treatment care of improved quality.

Financing and costs

As of December 31, 1970, children and youth projects were caring for 434,300 children and young people a year, at an annual estimated cost of \$6,897,546 (representing both the Federal and matching shares), or an average of \$140.22 per child per year—an average within the range of \$100 to \$200 usually estimated as needed for medical and dental care of a child per year.⁷ Projections based on the annual reduction in hospital care per child in this program will reduce this average to \$129.80 by June 30, 1971.⁸

Applying the projected average C and Y expenditure of \$129.80 per child per year, the annual cost of providing comprehensive health care to all 9,500,000 children and youth in the United States would amount to approximately \$10.5 billion or 172 times the total present funding of the C and Y program.

According to estimates for 1967, total annual expenditures from all sources for the health care of children under 15 years of age amounted that year to \$6 billion, three-fifths the estimated cost of pro-

viding comprehensive care to all children and youth as based on the C and Y projections. Of these 1967 expenditures, one-tenth came from the Federal government, two-tenths from State and local governments, and the other seven-tenths from insurance benefits and direct payments from families.⁹

Even limiting the provision of comprehensive health care to the 16,100,000 children and youth in families classified as medically indigent, the annual cost of providing comprehensive health care at \$129.80 per child per year would be nearly \$2 billion if all such children were included and would require over 33 times the present level of Federal, State, and local funds for the C and Y program.

By far the largest and most rapidly growing proportion of Federal expenditures for health care of children comes through the public welfare program, Medicaid, which channels funds for payment predominantly into private physicians' offices. Furthermore, the seven-tenths of all annual expenditures for health care of children that comes from private sources also are predominantly made to private physicians. How much planning for preventive care, auxiliary services, and followup attention is involved in such expenditures is unknown.

From the viewpoint of paying for comprehensive care several steps are open, which may be taken in concert or as alternatives:

1. The appropriation of additional funds for the comprehensive health care of children and youth.
2. Decreasing the annual cost per child for comprehensive health care for children and youth. Experience has shown a steady decline in the costs of C and Y projects the longer the children are in them, presumably because of the effectiveness of preventive care.
3. Diverting funds used to pay for episodic health care of children and adolescents to programs providing for comprehensive care.

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In any event, funds will have to be drawn from all existing sources—government at all levels, voluntary insurance programs, and payments from individuals. Or, at least, funds from all available sources will be needed until comprehensive health care for all children and youth is provided for through a national health insurance program.

Current C and Y projects

The University of Minnesota Systems Development Project, established for the continuing evaluation of C and Y projects, recently analyzed the patterns of delivering care in such projects according to the geographic and administrative location of their base.¹⁰ Some interesting differences were revealed.

Of the 58 C and Y projects analyzed, 19 were administered by medical schools, 22 by other teaching hospitals, and 17 by health departments. Forty-three of the 58 projects were located in central cities, nine in peripheral urban areas, and six in rural areas.

As was expected, the projects planned and administered by health departments had close working relationships with schools, welfare agencies, and visiting nurse services because of their past affiliation with such organizations. Four of the six projects serving rural areas were administered by health departments, which are more likely to be available in rural areas than teaching hospitals or medical schools. Other advantages of locating comprehensive care programs in health departments, affirmed by the study, are the possibility of influencing existing health services and integrating them into the program and the greater likelihood of outreach for case-finding and followup of children in need of service.

The analysis showed that where C and Y projects are administered by medical schools or teaching hospitals, children already known to the operating institution are frequently referred for care. In these projects, children are more often hospitalized; this might mean that the children in these projects are more likely to have a serious or potentially serious condition, or it might mean that there is some unnecessary hospitalization of children.

C and Y projects based in medical schools or teaching hospitals would be expected to find it easier to provide medical and dental care than health departments, although dental care is less easily available than medical care. However, the study showed that C and Y projects based in teaching hospitals had a higher percentage of children "registered only"—

that is, awaiting assessment—than either of the other two types of projects. Only in regard to dental care were the teaching hospitals apparently able to deliver care more expeditiously than health departments. However, projects in medical schools reached and served more children in their target areas than teaching hospitals.

Some advantages of basing a C and Y project at a teaching hospital or medical school, not mentioned in the analysis, are that it may make a higher quality of medical care available, it is more likely to be useful for teaching purposes, and it is more likely to conduct research.

Under any auspices, a comprehensive health care program for children and youth has the following responsibilities:

- Providing extensive coverage for children in its target areas.
- Reaching out to promote and accept referrals from community agencies; working with them to keep them informed; and utilizing their resources, skills, and followup services.
- Accepting children immediately for examination and care without a waiting period.
- Providing preventive, diagnostic, treatment, and rehabilitative services for all children in the family.
- Providing hospitalization, but keeping it to the necessary minimum.
- Making the service easily available for training medical, paramedical, public health, and allied health personnel.
- Conducting research to determine the relative effectiveness of various methods of delivering services in improving the health of children.

Total family care

In the future, comprehensive care of children and youth in one form or another will need to be an integral part of comprehensive care for all family members, or at least much more closely linked to total family care than at present.

One example of presently fragmented services is the lack of coordinated planning and administration between the 53 maternity and infant care projects and the 59 children and youth projects. Only 19 communities have both an M and I and C and Y project. More communities would have had both types

projects if the expanded funding anticipated for these programs a few years ago had been forthcoming. However, at present in only about one-third of the communities with M and I projects can all families and all family members receiving care under M and I immediately and automatically graduate to C and Y.

To be truly comprehensive, the delivery of health care ought to be so organized that any woman of childbearing age receiving any type of medical and health care for herself would also have all of her children and her husband cared for, and any child receiving care would also have his siblings and his parents cared for. Maternal care, family planning, and abortion counseling and service would be linked with child health services as would specialized services for adolescents. Well-child conferences would no longer be confined to preventive and counseling services, but, as outposts in a comprehensive program, could increase their casefinding efforts and would provide treatment for some illnesses. Schools would be integrated into the program with improved casefinding, health education, counseling, referral, and followup services. Head Start programs, day-care centers, nursery schools, and parent and child centers, closely linked together to provide an enriched program of social, recreational, play, and educational experiences for infants and preschool children, would also be integrated into the health care delivery system. Many families may put lower priority on their health needs than on other immediate and basic needs—housing, food, clothing, jobs, legal advice. Thus, the planning for comprehensive health care ought to be a part of planning for a total spectrum of services including—in addition to programs to meet these basic needs—programs to provide education for preschool and schoolage children, day care for children, guidance and vocational assistance to youth, services to neglected, abused, and emotionally disturbed children, comprehensive services to teenage pregnant girls, counseling and treatment of teenage drug users, family planning and abortion services, family life and sex education, and services to prevent and control delinquency and venereal disease.

At this point, a word of caution is pertinent. In the rush to provide a system of integrated comprehensive health care for all children, all parents, and everyone else, steps must be taken to safeguard the quality of care. For example, standards of patient care should be established by experts; qualifications for staff should be established and adhered to; pre-service and in-service training programs should be

continuously carried on; consultant services to provide certain specialized knowledge and skills should be available; supervision of personnel should be continuous. Research on the effectiveness of methods of evaluation and care should be carried out.

Innovative programs in the delivery of health care, such as the C and Y projects and the neighborhood health centers, have an opportunity to experiment with methods of health evaluation. The availability of a multidisciplinary team, of continuity of care, and of a close family-staff relationship—characteristic of these programs—make such experimentation possible. Information is needed on the reliability of certain types of medical tests, the productivity of such tests, their costs, and their specificity. The Pediatric Multiphasic Program at Kaiser Hospital, San Francisco, is currently using a battery of 17 tests to obtain such information.¹¹

Other studies greatly needed are:

- Studies of the health status of children and adolescents from low-income families, and also of their parents, to determine the health needs of this group of the population.
- Comparative studies of the cost and effectiveness of various methods of delivering health care.
- Comparative studies of various methods of casefinding.
- Studies monitoring patient care, to determine the end results for the child and his family.
- Studies of recipients' opinions, reactions, and suggestions regarding their health care.

Manpower needs and use

A major problem is the availability and use of health manpower. If current projections are correct, the 1970's will see some reduction in the serious shortage of physicians, but a substantial increase in shortage of dentists, nurses, and allied health manpower.

As important as the question of numbers of persons available to work in the health field is the question of how they are used. Numerous reports have been published on the use by pediatricians in private practice of persons in allied health fields. For example, a nationwide study¹² recently found that many pediatricians employ registered nurses to perform clinical, laboratory, technical, and clerical tasks. Tasks classified as "patient care" were less

frequently delegated by physicians than technical or clerical tasks. What tasks and how many were delegated was, of course, influenced by the number and qualifications of health workers employed.

The study indicated that the patient-care tasks most frequently delegated to nurses by pediatricians were the acceptance of telephone calls—the most urgent and least controllable pressure in practice—and tasks described as the most easily “routinized,” such as initial history-taking and giving instructions to the patient. The tasks least frequently delegated were those involving clinical judgment in a close patient relationship, such as making physical examinations and taking interval histories.

Many of the respondents indicated that they would be willing to delegate more patient-care tasks if trained allied health workers were available.

Other studies have reported favorable responses by parents to the use of registered nurses as pediatric nurse practitioners or as pediatric assistants.^{13, 14} The Chicago Head Start program has used pediatric nurse practitioners to perform physical examinations for screening purposes and has found their performance satisfactory.¹⁵

Except in the use of nonprofessional aides and dental assistants, few analyses have been made of patient care in relation to the roles of various professional and nonprofessional health workers. Innovative programs, such as C and Y projects, neighborhood health centers, and Head Start health programs could lead in experimenting in this direction with a view of determining the most efficient use of health workers of various types.

Information about innovative approaches to health care ought to be disseminated as quickly as possible so that such approaches can be used in the training of medical, paramedical, and nonprofessional health personnel at all levels of their education—undergraduate, internship, residency, postgraduate, and field placement and observation. The training should be concerned with individual and family care and also with the administrative aspects of providing service, including planning, operation, and evaluation.

Health personnel undergoing post-graduate training in schools of public health especially need exposure to the new approaches to health care, as they are likely to be key planners of future efforts to improve the system of providing health care for the Nation's children. However, continuing education of all types of health workers involved in the care of children is essential.

Ideally, comprehensive health care of children and youth provides preventive, curative, and rehabilitative care on a continuing basis.⁴ It begins prior to conception and continues throughout infancy, childhood, and adolescence. It includes the medical, dental, social, emotional, educational, vocational, recreational, nutritional, housing, and environmental aspects, as well as day care, homemaking, baby sitting, and transportation. It is interdisciplinary. It is coordinated by providing for quick referral of the child and his parents to whatever service is needed and for interchange of information between the services. It is easily accessible and available, 24 hours a day, 7 days a week. It provides for careful health and social appraisal of each child and the members of his family. It provides methods to safeguard the quality of care. It incorporates continuous planning to assess resources, define goals, determine unmet needs, establish priorities, and provide the indicated care. It includes participation by both the providers and the consumers of health services in the decisionmaking process.

¹ Overriding concerns of the White House Conference on Children and the 25 forum recommendations of the White House Conference on Children. *Children*, March-April 1971.

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RESEARCH for SERVICE to Severely Retarded Children

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Most social agencies are faced with demands greater than their financial resources. Because of this fact, there are those who deplore the use of every penny not spent on direct service. We would submit, however, that in such a situation research is a must to help the agency use its limited funds in the most effective way possible.

Experience at the Retarded Infants Services (RIS) in New York City provides an example of the use of research as a tool of service in a small voluntary agency with very limited resources. RIS deals with problems involved in the care and treatment of severely retarded children and their parents. Once concerned almost exclusively with children under 5, it now also serves severely retarded older children. The agency provides information and referral services; psychiatric and psychological consultation; home aides to help families care for their retarded children; parent counseling, individually and in groups; and supervision of a parents' visiting service to parents of mentally deficient newborns. In addition, RIS also undertakes special projects: home care to high-risk pregnant mothers, early casefinding in areas of poverty, and the training of home aides. Thus, the primary focus of Retarded Infants Services is service. Research is secondary. But why does the agency divert any of its resources away from its

helping efforts? The answer lies in the very shortage of money for service.

First, because its resources *are* limited, RIS believes that it has a responsibility to learn how to make the most forceful impact it can with what it has. It assumes that it can serve more people better and more efficiently if it knows how to look for better ways of providing service. And research is its way of looking.

Second, because RIS has focused its efforts on a relatively neglected part of the population, the severely retarded child in the community, it has been compelled to innovate viable programs where no programs have existed. While innovation requires imagination only, viability requires knowledge.

Given the realities of its service orientation and shortage of funds, RIS must confine its research to studies that can show concrete results: acquiring information to be used in developing new programs; providing feedback on the strengths and weaknesses of existing programs; and evaluating both old and new programs so that appropriate decisions can be made as to which should be scrapped, which modified, and which expanded. Research into more basic questions must, unfortunately, be left to others or to that hoped-for day when the agency's budget is a source of comfort rather than stress.

Given this rationale, Retarded Infants Services has in the past decade carried out studies on the following subjects:

1. The value of homemaker service in the family with a retarded child under five.
2. The feasibility of training unskilled personnel to assist professional staff in the care and treatment of mentally retarded children.
3. A survey to evaluate and identify the unmet needs of severely retarded children living at home.
4. The best method to recruit foster home care for mentally retarded children.
5. The incidence of early identification in 14 selected hospitals in New York City.
6. A client evaluation of the agency's services.
7. A comparison of mothers who place their children at birth and those who keep them at home.

Based on a paper presented at the annual convention of the American Association on Mental Deficiency, Washington, D.C., May 1970.

The first two studies received support from the Children's Bureau, the third and fourth from the New York State Department of Mental Hygiene, and the fifth from the New York Community Trust. Studies six and seven were supported by the agency's own budget.

How can these studies contribute to development, feedback, and evaluation of the agency's services? The results of some of them have already been reported¹⁻³; others are still in process. We will here give examples of the purposes of some of these. However, we will discuss in more detail our recently completed study, "The Survey of Unmet Needs of Severely Retarded Children Living at Home."

Two of the studies, the "Value of Homemaker Service" and the "Feasibility of Training Personnel to Assist Professional Staff," illustrate both the feedback and evaluation function of research. In undertaking the homemaker study, we had no doubt that parents of a severely retarded young child would welcome the extra pair of hands provided by a home aide. But how far would parents go in accepting a broader role for the aide? Would they accept the home aide as someone who had useful knowledge for dealing with a retarded child and who was qualified to train parents to care for such a child? In addition, the agency needed to know what problems characteristically arise in a family with a retarded child so that the home aide could be prepared to deal with them. Finally, it needed to know whether the women who served as home aides could be prepared to deal with retarded children and to train their parents to do so.

In the second study, the feedback role of the research was critical. The agency trained three successive groups of lay people to serve as assistants to professional staff. If the experience with each group was to be used to improve the program, some reliable means had to be developed for monitoring the program, including the procedure used to select trainees, the training itself, and the placement procedure. Further, if the report of the study were to show more than simply acceptance or rejection of the assistants, we needed to understand the factors determining the acceptance or rejection.

Another study (number 7), now being prepared for publication, deals with a major question that continues to be unresolved in the field of mental retardation: when should a child be institutionalized and when should he be kept at home? This is particularly a problem for RIS because of its emphasis on severely or profoundly retarded newborns and in-

fant. The question of whether or not to put the child in an institution is one that sooner or later the agency is forced to deal with by its clients.

What does one tell or advise the parents when the question is raised? The degree of severity of the retardation is certainly critical, but it is not by itself a sufficient determinant of the nature of the advice. What the parents' decision should be depends on many other factors in the situation—social and economic status, the quality of their marital relationship, the effects of the retarded child's presence on other children in the family, the mother's mental health and her motivations for placing or keeping her child. To begin developing guidelines for RIS staff members in this sensitive area, the agency carried out this study of the psychological motivations influencing the decisions of mothers of neonates afflicted by Down's syndrome (mongolism).

The three studies just described are "producer oriented"—that is, they are concerned with what the agency ought to offer families with severely retarded children. But it is also important to look at the "marketing side" of an agency's activities. How do the families that have come into contact with RIS perceive the agency? To answer this question, 80 parents seen by the staff in a 3-month period in 1969 were sent a questionnaire a year after their initial contact. Many of the parents' comments on the results turns helped pinpoint what are probably common disjunctions between client needs and the administrative structures and policies of social agencies. From a service perspective, perhaps the most interesting finding was the prevalence among the parents of the feeling that they had been unable to articulate their needs and that RIS should not have taken "no" for an answer when its offer of a particular service was refused. In other words, when a client of a social agency is under severe stress, a passive acquiescence to the client's right of self-determination may not be what the client needs or wants.

Unmet needs

An example of the use of research as a basis for program development is provided by the recently completed study, "A Survey to Evaluate and Identify the Unmet Needs of Severely Retarded Children Living at Home." This study was designed as a corollary of one carried out by the New York State Department of Mental Hygiene: "Appropriateness of the Continued Institutionalization of the State School Population in New York State." Because RIS p

narly serves families with severely retarded children, the Department chose it as the appropriate agency for studying the needs of families keeping retarded children at home although institutionalization had been recommended for them because of the severity of their retardation.

The data collected in the course of the study are detailed and complex. They touch on such questions as the social, familial, and psychological factors affecting the decision to maintain a severely or profoundly retarded child at home as well as on the consequences of this decision. Here we will discuss only the problems and needs of families that have made such a choice as these have been reported by the parents.

The study sample consisted of families with a child who—

1. Had a general IQ level below 30.
2. Was between 2 and 16 years of age. (The lower age limit was set to eliminate two types of situations: those in which a child was home because of the common 2-year delay between application and institutionalization; and those in which a decision to keep a child at home was almost immediately changed.)
3. Was at home within the primary family unit despite a recommendation for institutionalization.

Records from four agencies were used: RIS; Mental Retardation Center, New York Medical College and Flower Fifth Avenue Hospital; Children's Developmental Evaluation and Rehabilitation Clinic of the Albert Einstein College of Medicine, Yeshiva University; and the Association for the Help of Retarded Children. Altogether 67 families that met the criteria were identified. Of those, 27 were not contacted, because they lived outside of New York City or could not be located. Of the 40 families contacted, 37 agreed to be interviewed.

In 19 of the 37 families, both the husband and wife were interviewed; in 18, the wife only. Data were collected through the use of a semi-structured schedule that asked about the basis for the decision to keep the retarded child at home, the child's needs and problems, the effect on the family of the child's presence in the home, and the family's use of social services.

The families were predominantly white, Catholic, or Jewish, with varying but stable incomes. The retarded children ranged in age from 4 to 18; the median age was about 8. Nineteen of the children were boys; 18, girls. At the time of the interview, 27

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of these children were still at home, eight were living in institutions, and two had died.

The records showed that of the 37 retarded children, 25 had been considered untestable for an IQ score. Half had been diagnosed as having severe brain damage, one-fourth as having Down's syndrome. All of the children suffered in varying degrees from handicaps related to their retardation—convulsions, seizures, multiple anomalies, epilepsy, and so forth. Furthermore, the level of self-care achieved by the children at the time of the interview was extremely low—30 were completely dependent on others for washing and bathing, 26 for dressing, 23 for toileting, and 15 for eating. By any definition, these children were severely retarded.

With respect to problems encountered in learning about their child's condition, the parents were first asked when the initial diagnosis was made. Despite the severity of the children's retardation, the parents of 14 children, or almost half the study sample, reported that their child's condition had not been diagnosed until the child was more than a year old; four of these children had not been diagnosed until they were more than 2 years old.

The parents were also asked to recall what they were told at the time of diagnosis. Only eight reported having been given more than just the medical diagnosis: of these, three had been given a recommendation to place the child in an institution; two, hope for possible improvement; and three, a very general prognosis, such as "she will develop slower than others in her age group." The rest were left hanging.

When asked about the information or help they would have liked to receive, the parents emphasized practical information: being told what a severely or profoundly retarded child is really like and where they could go for help. In fact, throughout the interviews, the parents had a continuous refrain: "Had I but known what it really meant!"

A picture of the effects of maintaining the retarded child at home was obtained through the parents' responses to a number of open-ended questions. Five recurring themes emerged:

1. The need for help with the problems of learning how to deal with the child, how to train and discipline him, and how to cope with the unremitting strain of caring for him day in and day out.

2. The constriction of the parents' social life. Few of the parents ever go out of the home for recreation, entertainment, or visiting with friends. Many do not even entertain in their homes. For the majority, social life consists of visits by and to other members of their families. Those for whom this is the preferred life style appeared to be the most satisfied with the decision to keep their child at home.

3. The inability to take a family on vacation away from home. Many of the mothers were concerned about the effects of this constraint on their husbands and the other children.

4. The inability to give appropriate attention to other children in the family because of the demands of caring for the retarded child.

5. The economic burden imposed on the family by the child's condition—bringing high medical expenses and at the same time preventing the mother from working to increase the family's income.

To learn about the relations of these families to social agencies, the investigators asked the parents to list all the agencies they had thought of approaching for help. They had thought of and approached many. Twenty of the families, for example, had gone to four or more agencies. And, in nearly all instances, they had received some service from the agencies they approached.

The parents were also asked about the sources of their knowledge about the agencies, whether formal (professional) or informal (family and friends). Ten specified formal sources only; seven, informal sources only; and 17, a combination of formal and informal sources. In this last group, the informal source tended to be the launch point to service, a personal referral to an agency that then passed the family on to another community resource.

Finally, the parents were asked about problems they had had with agencies. Three-fourths reported some kind of problem, the most frequently mentioned being delays in getting service (13), difficulties in

dealing with staff members (10), and needs not met (8). It is our impression that the parents' difficulties with staff members frequently revolved around a conflict between the parents and the professional worker over the parents' reluctance to accept a recommendation to place their child in an institution. Other problems mentioned were "buck passing" from agency to agency (4), no appropriate resources (4), and duplication of tests and services (2).

Because this study was supported by the State of New York as part of its mental retardation program, the focus of the report was on developing general policy recommendations. But the concern here is with the use of these results by RIS in its own programming. The study has affected the agency in many ways, including the following:

1. The agency's decision to serve profoundly and severely retarded children over 5 years of age grew out of the findings showing the lack of adequate services for such children and their families. As a result of this decision, the agency extended its home aides services to provide training to parents of such children.

2. The agency's decision to undertake the research project on early identification in hospitals was supported by the parents' reports of delay in diagnosis.

3. The agency is negotiating to establish a facility where the retarded child may be left for a few hours a day, several days, or even for short vacation periods.

Other new services or modifications of existing services will undoubtedly come about at RIS because of this and other studies. However, the significance of the RIS research experience derives not from any one study but from its demonstration that even small agencies with limited resources can develop a viable research program. Of course, the research must be guided in its goals by both the aims of the agency and the limitations of its resources. But it is certainly our belief that RIS would be a much poorer agency in programming and services if it had not made its commitment to research.

¹ Arnold, I.; Goodman, L.: Homemaker services to families of young retarded children. *Children*, July-August 1966.

² Training and utilization of nonprofessional personnel in services to the retarded. *Mental Retardation*, December 1967.

³ Budner, S.; Arnold, I.; Goodman, L.: The plan and the reality: training and utilization of paraprofessionals for service to the retarded. *American Journal of Public Health*, February 1971.

PSYCHOLOGICAL CONSULTATION in a PRESCHOOL

LAWRENCE BALTER

A few years ago Lois Barclay Murphy wrote a clear and comprehensive article on the role of the consultant in a day-care center for deprived children.¹ The principles she pointed out apply equally well to the role of the psychological consultant in a nursery school for economically disadvantaged children.

Single instances aside, there tends to be a greater difference in role between the consultant in a private nursery school that caters to a middle-class clientele and the consultant in a preschool program established to serve children and their parents in low-income neighborhoods, especially those in which the children's parents and other members of the neighborhood play an active part.

The role of the preschool psychologist varies with the setting in which he is working. Among the factors influencing it are the location, the size of the facility, the number of children enrolled, their socioeconomic background, the sophistication and size of the staff, and the availability of competent members of other mental health professions.

Therefore, in discussing a psychologist's role in a nursery school it seems pertinent to consider two points: (1) his role in regard to problems that are peculiar to a preschool program for children of poverty; and (2) his role in building a positive relationship with the adults involved in the program— an essential part of the consulting role in any type of nursery school.

Before turning to the first point, a note of caution is in order. While the consulting psychologist by virtue of this training and experience may be in a position to conduct research, administer psychological tests, consult with teachers, parents, and children, and engage inservice training pertaining to child development needs in relation to curriculum, the nature of his role is essentially advisory. This means he offers information that is intended to be helpful to those with whom he works. Decisions on program or other school operations may be based in part upon his suggestions, but they are the responsibility of the school's administrator or director. Similarly, the choice of whether or not to follow the suggestions he may offer is the prerogative of the recipients. For him to assume otherwise would be presumptuous as well as damaging to his role as a consultant.

Staff tensions

In a preschool for disadvantaged children in which the children's parents and other members of the community are actively involved, the staff may consist of persons varying widely in background, degree of training, and experience. Lines of authority and responsibility within the classroom may become blurred, resulting in interpersonal tension within the teaching staff. Actual leadership may not be the same as titular leadership. Such a confused situation may develop particularly in schools where the hierarchy of

the teaching staff has been casually set and where willingness of the staff members to talk openly of their problems is influenced by ethnic, social, racial, and personal factors. For example, a family liaison worker who works in the community where she lives and who is developing her skills while on the job, may be reluctant to discuss a problem she has encountered in the course of her work with the head teacher—the person to whom she is technically responsible. She may feel a great deal more comfortable consulting a staff member who is her neighbor and longtime friend.

Another source of tension can arise from the distribution of authority that favors formal education over experience. For example, a young middle-class person trained as a nursery school teacher may be appointed to the position of educational coordinator, or head teacher. She does not live in the community, she is single, and she is identified with middle-class mores. Working under her is a woman from the neighborhood who has been with the preschool for several years, has been an active participant at board meetings, has numerous social and political contacts in the community, and is a parent. Each may feel she knows best what the children need.

Unless the director understands the incipient conflicts in such situations, serious misunderstandings may ensue. The psychologist may point out these dangers and he may also help both the superior and subordinate broaden their perspectives and gain greater respect for one another's competencies. However, such situations also hold pitfalls for the psychologist, for he may find himself in a position similar to that of the young head teacher just described. I will explore this problem further when I discuss the "relationship" aspect of consultation.

Seminars, staff meetings, or conferences with the people involved often serve as useful vehicles within which to work out such problems. The formulation of new role definitions may in some instances make more sense than adhering to standard operating procedures. In any case, staff feelings, as well as reason, have to be taken into account.

Staffs that are composed largely of paraprofessionals from the neighborhood being served may be subject to frequent turnover in personnel. Some paraprofessionals move up the career ladder to administrative positions. Others leave because they become involved in other community activities when their own children "graduate" from the nursery school and enter public school. Still others leave because of pregnancy. Some intend from the beginning to stay only

temporarily. Among these are the young people who leave to continue their education or enter other type of work and the free-lance artists who leave, return for a while, and then move on again. Some of the latter "creative noncompromisers," as Dr. Murphy has called them, have proved to be so gifted in dealing with young children that in spite of their tendency to wander, they usually are welcomed back.

Personnel changes in a preschool may have important effects on both the remaining staff and the children. They have to adjust to the loss of a familiar person and simultaneously accommodate to the addition of a new face and personality. Persons with little experience in work with children or whose sense of assurance depends for other reasons on a stable structure may become apprehensive. The continuity of the program may be disrupted. "Farewell" and "welcome" events may be both instructive and emotionally clarifying at such a time.

The consultant can be helpful by serving as a kind of stabilizer. Through group discussions, he can help the staff members maintain a sense of stability, provide the newcomers with a sense of what has been accomplished in the program and the rationale for its present activities, and buttress the efforts of the entire staff to progress toward previously agreed-upon goals. He can work toward preparing the children in advance for the departure of one person and the arrival of another and can help the staff anticipate the children's reactions to the change. He may also help staff members bring out their feelings about such changes in their working companions. When feelings are brought out, a reappraisal of the strengths and special skills of individual staff members evolves and even the program changes in the process of staff adaptation.

Parents and staff

In a preschool where parents are integrally involved in the school's functioning, it is common practice for parents to be invited to observe the child in the classroom and sometimes to work there as volunteers. This practice has many assets. However, misunderstandings on the part of both teacher and parent, or genuine disagreements between the two concerning the other's performance, are not unusual. Occasionally, too, personal hostility, unconscious rivalry, or other very human reactions may enter the picture. Often there develops a highly personal problem where both persons are inclined to behave defensively. The parties in question may not have

ill or experience to resolve the conflict successfully. Here the consultant can make a major contribution by helping the parents and the staff members establish procedures together that facilitate communication between members of the two groups. Structural arrangements for problem solving, regardless of the type of problem, can be doubly useful. They provide not only a way for dealing with the conflicts they were established to resolve, but also an approach to resolution of future difficulties.

For example, most preschool centers hold regular staff meetings. In a parent-organized setting joint parent-staff meetings have proven to be a worthwhile approach to the solution of problems. In principle the idea is simple. However, in practice it may be extremely difficult to implement. Frequently, parents are reluctant to enter into discussions involving curriculum and staff members are equally reluctant to have "outsiders" sit in on discussions of curriculum and classroom management.

Whatever reasons for reluctance may be cited by either side, the goal of such meetings is to dissolve the notion of "sides" and to develop instead a unified working group of concerned adults. One way to help parents overcome their reluctance to attend such meetings is to offer them inservice training in child development and early childhood education so that they become sufficiently knowledgeable to feel confident and secure in discussions with the professionals. Despite the difficulties, the development of a joint staff-parent group has advantages far outweighing the problems of implementation.

A point of lesser importance concerns conflicts that may arise from overlapping roles. Some members of the instructional team may be parents of children who attend the school. Occasionally a child and his parent may be assigned to the same classroom. While this kind of arrangement may be worked out to meet a special situation in the family, it often presents problems for both the child and the parent and also

for other children in the class. More rarely, a staff member who is also a parent of one of the children may be elected by the parents to serve on the governing board, a situation which may also result in discomfort, friction, and suspicion among the members of the teaching staff.

When such situations are imminent, the consultant may point out that an overlap in roles and functions contributes significantly to myriad problems. Such a step, however, must be taken prudently, as personal aspirations, political motivations, and other highly idiosyncratic factors may be at work.

Use of relationship

Whether the consultant addresses himself to matters of staff relationships, parent-staff involvement, program stabilization, or organizational issues, his effectiveness depends largely on the quality of the relationship he has developed with the nursery school as a whole and with its various component groups. The goal of developing a positive relationship goes beyond dealing with the issues that may arise, though this is certainly part of the goal. The ultimate purpose, however, is to help each person with whom the consultant works achieve independence and confidence in his own ability to function appropriately.

To achieve this goal the consultant must assume that the people with whom he works will develop a desire to take over *for themselves* and *as part of themselves* certain attitudes and modes of behavior that are actually part of the consultant's repertoire. Before those with whom he works see this goal for themselves, however, an intervening process of identifying with the consultant must occur, using his behavior as a model in the solution of problems. To the extent that the psychologist's attributes as a consultant are absorbed, each staff member is able to function as a consultant for himself.

Thus helping the consultee achieve identification with the consultant becomes a kind of subgoal. How to achieve a relationship that facilitates the process of identification is a question that cannot be answered easily or completely. Powerful forces operate continually to counteract the desired outcome. There are, however, several principles that are helpful in such an effort. For instance, a positive relationship depends in large part upon mutual respect and trust. The consulting psychologist comes to the preschool with a specialty that is the product of many years of formal training and experience. But this very background of formal training and professional ex-

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perience may in a sense be a handicap, for it may cause him to be perceived as a representative of the "establishment."

In some economically impoverished communities an association with the establishment conjures up negative stereotypes that sweep across any number of disparate individuals, groups, agencies, and institutions. The more pervasive the anti-establishment and anti-intellectual sentiment within the preschool and surrounding community, the greater the difficulty the consultant has in building the mutual respect and trust necessary for a positive relationship. Where such a general stereotype exists, the consultant will be unlikely to alter it appreciably. However, he may be able to free himself from this stereotype in the perception of those with whom he is working.

Whether the consultant is casual or relatively formal in his personal style, he may take several definite steps to promote the necessary confidence and trust. Because his role is never clearly defined, it need never become rigid. This makes his assimilation into the nursery school easier. The form of the assimilation may vary, but it should always serve to lessen the image of himself as an "outside authority" brought in to execute rapid solutions.

When the psychologist first comes to the nursery school, he may find it helpful to demonstrate some immediate usefulness by performing a specialized function such as psychological diagnosis or referral of children to community resources for needed services. More general duties such as pitching in wherever help is needed can also aid the assimilation process. Taking the initiative in arranging for a meeting or a workshop may also help. Such activities often give staff members a clearer idea of what the consultant can do or when to call on him. Needless to say, taking appropriate initiative requires good judgment and careful timing.

Of greater importance in the development of a relationship that lends itself to identification with the consultant is the *consistency* with which he maintains an *objective stance*. Whether the presenting

problem concerns a teacher's handling of a child, a staff member's personal problem, or even a criticism of his own work, the consultant must attempt to examine the situation in a systematic and not emotional fashion. He must make it clear to parent and staff members that, at least, he can be depended upon to (1) listen carefully to their expression of their thoughts and feelings; (2) uncover as many of the relevant facts as he can; (3) try his best to determine underlying as well as manifest contingencies; (4) look at the problem from various perspectives; and (5) respond and interpret the events according to his best judgment.

Such an approach is taken in the interest of helping his coworkers express their goals and work toward their stated objectives. In the process the consultant and the staff member involved explore alternatives and the possible consequences of any plan of action considered. In this way the consultant offers immediate assistance as well as a method that the staff member can use for himself in problem solving. Maintaining an objective stance, an understanding attitude, and an obvious willingness to help, the consultant works with the staff member in searching for potential solutions to whatever problems arise. Such a joint endeavor lays a foundation for the construction of a positive relationship, one that will facilitate the process of identification in the staff member and with it his gradual assumption of the consultative role.

The foregoing description of the psychologist's role in developing a relationship with nursery school staff member is but one feature of a multifaceted arrangement. There can be no effective relationship without a dynamic interchange among all members of the school staff. More than a reciprocity between consultant and staff is involved. The goal is for all staff members to become both recipients and givers in the consultation experience.

¹ Murphy, Lois Barclay: The consultant in a day-care center for deprived children. *Children*, May-June 1968.

DEMOCRATIZATION OF EDUCATIONAL OPPORTUNITY

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Future historians who pursue a conspiratorial approach to the study of social phenomena may regard the great concern with ethnic segregation in the mid-twentieth century as a ploy to divert attention from more critical problems in the democratization of educational achievements. Nonetheless, a careful reading of Weinberg's "Desegregation Research: An Appraisal"* and a serious analysis of the findings and judgments resulting from the research it reviews, inevitably lead to the conclusion that while ethnicity continues to be an important factor influencing *access to opportunity* in our society, *quality of opportunity* and *quality of achievement* are largely functions of social class. Weinberg does not deal explicitly with this issue nor does he develop the argument. Rather, he confines himself to summarizing the major findings and trends in this field of research.

After reviewing the research on desegregation, Weinberg concludes, as have others,^{1, 2} that ethnic integration in public schools is clearly associated with gains in achievement for black children but not so clearly for native American (American Indian) or Mexican-American children. White children involved in desegregation experiences—*are advanced from the start* than the children from the ethnic groups—*continue to learn at their accustomed rates*. Weinberg presents a number of other findings. But if one moves from this central finding to a consideration of

policy implications, it becomes clear that an indicated treatment for low academic achievement among children from minority groups is the integration of these children in learning situations with children of the majority. However, the simple moving of ethnic groups apparently is not adequate. Other findings in the research Weinberg reviews suggest that success depends on important conditions: (1) that the children of higher social status remain in the majority in the school; (2) that resegregation within the integrated setting be avoided; (3) that a systematic educational program be available; and (4) that the politico-social climate not be so chaotic as to preclude attention to academic learning.

The research reviewed clearly shows that ethnic integration in education is associated not only with improvement in academic achievement, but also with higher levels of aspiration and self-esteem in the minority group children. Improvement is also reported in the attitudes of students of the two groups toward each other as well as between students and teachers who are of different races. As Weinberg points out, "virtually none of the negative predictions (advanced) by anti-desegregationists find support in studies of actual desegregation."

Mechanisms of change

As evidence in support of these findings and observations mounts, researchers begin to turn from a preoccupation with the identification of correlations to a concern with the mechanisms by which the improvement in relationships may be explained.

It is here that the emphasis on ethnicity may be counterproductive. If we

conclude that something about the other children's being white improves the functioning of black children in integrated settings, we must also accept certain assertions concerning white supremacy and end up in open conflict with some of the assumptions that led us to move toward integration in the first place. We are also in open conflict with the ethnic culturalist and ethnic nationalist movements that in and of themselves may be potent forces for the improved development of black children.

Any assumption about the intrinsic goodness of whiteness for the educational development of black people is untenable. However, there are factors associated with being white and middle class in our society that can help explain the improved achievement of black children in predominantly white schools. One does not need to be an expert to think of a few of these: better school facilities, better and more stable teaching staffs, higher expectations of achievement, greater pressure on the school to produce, the sense of being well situated and possibly even capable of influencing one's future, to mention a few. These conditions derive from social status or class and are related to race only as race contributes to the differential allocation of status in our society.

When one goes back to the school desegregation data reviewed by Weinberg and examines the probable contribution of economic status to the association between desegregation and achievement among black children, the possible contribution of ethnic factors becomes unimpressive. However, in our social order, unfortunately, one cannot completely separate economic and ethnic status. The pervasiveness of racism hopelessly confounds the two.

*DESEGREGATION RESEARCH: AN APPRAISAL. Second edition. Meyer Weinberg. Phi Delta Kappa, Bloomington, Ind. 1970. 460 pp. \$3.75

Nevertheless, it is of great practical significance to distinguish between ethnicity and class as explanations of differences in access to and quality of opportunity. As long as we focus our attention on ethnicity and ignore socioeconomic status, we fail to see the following important facts:

- Academic underdevelopment is not limited to blacks and other ethnic minorities.
- Although black children improve in achievement following desegregation, the desegregated educational experience is not associated with an equalization of achievement.
- The effects of assigned social status and perceived differences in social conditions result in varied patterns of performance among children from lower status groups.
- It is unlikely that an adequately desegregated educational experience can be made available or acceptable to all minority group children in the Nation.
- The quality of educational opportunity and the quality of achievement are apparently advancing at a more rapid rate among children of the most privileged segments of our population than among the masses.

Some political pressures

Attention to these issues forces a consideration of the political economy of education. What is the relationship between economic values, political control, and distribution and quality of educational opportunity?

Access to the formal educational resources of societies has always been determined by the nature of the social order's need for educated or trained people. Who gets educated and how well they are educated depends on what the controllers of political power deem to be the requirements for the maintenance and orderly advancement of the society.

In the United States, the desegregation of the public schools could not emerge as a national issue until the political and economic requirements of the Nation demanded it. Universal literacy is essential for a nation in the advanced stages of industrialization, and the opening up of access to educational opportunity to all ethnic groups is an essential feature of a great power that needs friends in all parts of the

world. Such needs can help us understand the heavy emphasis on desegregation in the presence of gross and increasing inequities in the *quality* of opportunity available to children of different classes.

Weinberg reminds us that our national economy "requires specialists and manages to influence the educational structure of the country to accommodate to this need." But he fails to point out that we do not need a *mass* population of specialists and highly skilled professional and technical workers. In the absence of such a need, our schools have not been forced to equalize the quality of educational opportunities on a universal basis.

Regarding quality

We could continue to be selective and provide high-quality education for those middle- and upper-class members of society who want it and those lower-class and lower-status members whom we select. However, the political pressures for universal access to educational opportunity, once aided by international politico-diplomatic needs, now continue largely as a reflection of exacerbated domestic political demands. In response to these pressures, we democratize access to education through desegregation of the public schools and open admission to college without dealing with the basic problems of democratizing the *quality* of educational opportunity and ultimately the quality of achievement in our society.

To tackle these problems requires the restructuring of education, the redefinition of educational goals, and changes in society. If the Coleman data³ can be relied upon, four factors emerge as highly important to school achievement: (1) family background; (2) the extent to which a pupil feels that he has control over his own destiny; and (3) for children of low-status groups, the extent to which one's schoolmates are privileged in status and (4) the quality of the educational experiences.

To manipulate the factor of family background in the interest of improving educational achievement requires improving family income, social status, and quality of life.

To modify feelings regarding the control of one's destiny in the interest of educational achievement requires modification of the distribution of power to

reduce feelings of powerlessness among people.

To insure pupils' achievement according to existing norms requires ethnic integration since there are not enough middle- and upper-class people in the minority groups to achieve the indicated mix of high- and low-status children in segregated settings. But the subimposition of such norms may be only unacceptable to many members of these groups but also counterproductive to their development. We may need to change radically our criteria for educational experiences of high quality and high quality of achievement.

Perhaps society's perceived need for specialists and persons of high technical skill is in error. Could it not be that the 21st century will demand intellectual competence to pose appropriate questions, to organize experiences and information in the solution of problems and to synthesize knowledge, experience, and values into wisdom? Could it not be that the next century will require competence in self-expression and self-management in cooperative relations with others in creative and recreative pursuits?

To pursue such goals the structure and methods of schooling will have to be changed. Schooling of high quality will have to be concerned with development of intellect and values, not so much with the integration of races and cultures as with its integration with life and its purposeful integration of their lives. With such goals, education could replace economics and even politics as the ordering force of society, for the quality of achievement would then be measured by the quality of life available to men.

Desegregation of the public schools may be a step toward such goals. A reordering of priorities—social, pedagogical—the restructuring of education, and the more equitable distribution of power and resources must follow.

¹ St. John, Nancy H.: Desegregation and minority group performance. *Review of Educational Research*, February 1970.

² Pettigrew, Thomas F.: Race and educational opportunity. *Harvard Educational Review*, Winter 1968.

³ Coleman, James S.: Equality of educational opportunity. U.S. Department of Health, Education, and Welfare, Office of Education, Washington, D.C. 1966.

The Use of Stimulant Drugs in Treating Hyperactive Children

Diagnosis and close supervision by a physician and parental understanding and cooperation are keys to the proper administration of amphetamine drugs in the treatment of school-age children who have hyperkinetic behavioral disturbance, according to the report of a multidisciplinary panel of professional persons issued by the Department of Health, Education, and Welfare in early March. The report is the result of a 2-day conference called by the Office of Child Development and the Office of the Assistant Secretary for Health and Scientific Affairs to review the evidence of research and experience in the appropriate use of psychotropic drugs in treating school-age children.

Chaired by Daniel X. Freedman, M.D., who heads the Department of Psychiatry at the University of Chicago, the 15-member panel represented the fields of education, psychology, special education, pediatrics, adult and child psychiatry, psychoanalysis, basic and clinical pharmacology, internal medicine, and social work.

Pointing out that hyperkinetic behavior disturbance affects about three out of 100 elementary school children and is characterized by poor attention, disordered behavior, and excessive activity, the report stresses the importance of skilled diagnosis in identifying the condition. Among its conclusions are these:

- In many children with diagnosed hyperkinesis, the use of certain amphetamines, or stimulant drugs, improves attention, learning, and social abilities. Such drugs do not cure the condition but make the child more accessible to educational and counseling efforts. They have been found to benefit about half to two-thirds of the cases in which trials of the drugs are warranted.
- Before treatment is undertaken, diagnosis of a child with a behavior problem should take into account the child's environment, family relationships,

and other physical and psychological factors. Adequate diagnosis may, therefore, require the use of psychological, educational, and social as well as medical resources. The use of amphetamines is clearly not called for in children whose behavioral disturbance stems from hunger, emotional stress, poor teaching, or crowded classrooms.

- Amphetamines do not act as sedatives in children; rather they appear "to mobilize and to increase the child's abilities to focus on meaningful stimuli and to organize his bodily movements more purposefully." Unwarranted side effects are rare in the small doses used in the medical treatment of children and disappear with cessation of treatment.

- Thirty years of medical experience in using stimulant drugs in treating hyperkinetic children has produced no evidence that the children so treated have become drug abusers in later life. Dosages used in medical therapy are small in comparison with the dosages taken by drug abusers.

- While it is entirely proper for school teachers or administrators to draw parents' attention to a child's behavior problems, they should scrupulously avoid any attempt to force parents to accept any particular kind of treatment and should initiate contact with a physician only with the parents' consent. In any instance, treatment should be undertaken only with the informed consent of the parents and of the child if the child is old enough to understand.

- The child should not be given the sole responsibility for taking his medication. In most cases, it is not even necessary for the child to take the drug to school. The same precautions should be taken in the home against the misuse of amphetamines by children as against the misuse of any other medication.

- No stigma should be attached to a child who has been prescribed medication for behavior disorders: "his situa-

DRUG PANEL

Daniel X. Freedman, M.D.,
chairman
T. Berry Brazelton, M.D.
James Comer, M.D.
William Cruickshank, Ph. D.
Edward Perry Crump, M.D.
Barbara Fish, M.D.
George H. Garrison, M.D.
Frank Hewett, Ph. D.
Leo E. Hollister, M.D.
Conan Kornetsky, Ph. D.
Edward T. Ladd, Ph. D.
Robert J. Levine, M.D.
Patricia G. Morisey, D.S.W.
Irving Schulman, M.D.
Martin H. Smith, M.D.

tion is no different from that of the child who benefits from eyeglasses."

- Manufacturers of stimulant medications should promote their products solely through the appropriate medical channels and should not seek the endorsement of such products from school personnel.

- Abuses and misuses of drugs with children must promptly be called to the attention of the proper authorities. Physicians, educators, parents, and the news media share this responsibility.

The report also emphasizes the need for further research into causes, prevention, and treatment of all types of behavior disorders in children. It points out that, even when medication has improved the behavior disturbance, a child may require special attention for coexisting disorders—such as perceptual and learning problems—as well as for psychological, social, and family problems.

The panel warned against the use of amphetamines with restless school children as a substitute for improving the schools. It also warned against allowing negative public attitudes toward the appropriate use of drugs to deprive children of needed medication: "Either bad practices or exaggerated alarm can threaten the availability of medical resources for those who critically need it."

For a copy of the full report, send a postcard to Drug Panel Report, Office of Child Development, P.O. Box 1182, Washington, D.C. 20013.

HERE and THERE



Conference followup

As a first step in putting the recommendations of the 1970 White House Conference on Children into action, delegates to five regional followup meetings, held between February 20 and March 3, 1971, suggested that the 55 State Committees on Children and Youth be strengthened and those now operating under temporary appointments be established on a continuing basis. The National Council of State Committees for Children and Youth co-sponsored the regional meetings with the White House Conference. Both are offering to help State groups work with legislatures and governors to achieve this goal. More than one-third of the State committees were created on a temporary basis.

Altogether nearly 1,000 delegates attended the meetings, which were held in Omaha, Denver, Indianapolis, Atlanta, and Seattle. The delegates, were selected by the State committees.

Each regional meeting was focused on the development of strategies for implementing the recommendations of the White House Conference. Many of the delegates agreed that local conditions would determine the specific action taken in local communities. Among the methods suggested for initiating change were efforts to increase understanding by holding open houses and special tours of children's institutions and environments, recruiting volunteer workers—particularly the members of the lawmakers' families, young people, and children—and presenting discussions about services for children on television and in newspapers.

Other methods suggested for citizen action were conferring with government officials on programs and policies and lobbying with city or county govern-

ments, State legislators, and Congressmen for legislation to meet children's needs.

Naomi Hiatt, director of the Illinois Commission on Children, was chairman of the national committee for the regional meetings. Each meeting also had a regional planning committee.

Health Start

Health Start, an experimental program to extend comprehensive health services to disadvantaged preschool children not now receiving health attention, will be launched by the Office of Child Development in the summer of 1971 in 20 to 30 communities across the Nation. Initially, it will bring health care and health education to about 10,000 children under 6 years of age, including brothers and sisters of children currently enrolled in Head Start programs, children on waiting lists for enrollment in Head Start, and other children from low-income families who need health services.

In addition to increasing the number of children who receive health services, the Health Start program is intended to develop various methods of ensuring delivery of health services to children in communities with limited health resources. Projects are expected to draw on the resources of other programs, including Head Start health services, Parent and Child Center health services, comprehensive health care projects for children and youth, Medicaid, and the compensatory education programs established under the Elementary and Secondary Education Act.

All Health Start models will provide the following services for each child: screening tests to detect developmental problems; physical examinations; vision and hearing tests; immunizations;

routine laboratory tests and special tests for intestinal parasites, sickle cell anemia, and lead poisoning when indicated; dental care; and linkages for continuing health services, including the forwarding of records to school neighborhood health centers, or other interested agencies. While most projects will run for 4 to 8 weeks, treatment services will be continued under a long range followup plan until the child's needs are met.

Health education for children, the parents, and staff members will also be an integral part of each model. The curriculum will include information about the human body, disease prevention, nutrition, dental hygiene, and other aspects of health.

Each project will be directed by a health coordinator—in most cases, a registered nurse with experience in administration, teaching, and counseling. Where a registered nurse is not available, a licensed practical nurse or other experienced health worker will be employed. The coordinators, to be employed for a full year, will be given pre-service training in methods of providing Health Start services, coordinating and supplementing local health resources, and completing health service requirements of the program.

Grants for 1971 Health Start projects will be made in at least two communities in each of the 10 HEW regional Applications, which closed on May 1, are now being reviewed, and the grant will be awarded June 1.

Gertrude T. Hunter, M.D., director of health services for Head Start, national coordinator for the Health Start program.

Quasi-adoption

A quasi-adoption program, initiated in 1964 by the Children's Aid Society of Pennsylvania for black children in Philadelphia, has worked out well, according to a study conducted by the Society and Bryn Mawr College. The program subsidizes families with whom children are placed with understanding that the subsidizing family will care for the child through his childhood and perhaps legally adopt him.

Supported by a grant from the Children's Bureau, the study compared children between the ages of 3 and 5 in the quasi-adoption program with black children in the traditional ad-

ion program placed between September 1, 1961, and September 1, 1968. All the children in both groups had been placed with black couples.

The subsidized parents were slightly older and had slightly lower incomes than the parents taking children for adoption.

The investigators found that families in both programs showed high levels of family and child functioning. In rating the parental functioning, based on such qualities as acceptance of the adoptive child and affection, the study team gave the highest score possible to 77 percent of the mothers in the quasi-adoption program and 92 percent of the mothers in traditional adoption.

The study found no significant difference in the overall adjustment of children in the two groups as determined by interviews with parents, observations by the study team, and psychological tests of the children. In the area of intelligence, however, the adopted children scored higher than the children in quasi-adoption, who were older at the time of placement and had a greater number of negative factors in their lives.

In quasi-adoption, the agency retains responsibility until the child grows up and is legally adopted. Both groups of parents in the study received about the same number of supportive services related to family functioning from the agency. However, 98 percent of the permanent foster parents received financial help from the agency, compared with 5 percent of the parents in traditional adoption.

Elizabeth A. Lawder, D.S.W., executive director of the Children's Aid Society of Pennsylvania, was director of the research team.

Mental retardation

A system for providing comprehensive health care in residential institutions for the mentally retarded has been designed by Harold A. Decker, M.D., formerly of the School of Public Health, University of Michigan, on the basis of two studies of health care in such institutions carried out under his direction from 1965 to 1969. The studies received support from the Children's Bureau, the Maternal and Child Health Service of the Health Services and Mental Health Administration, and the National Institute of Child Health and

Human Development.

The first study consisted of data gathering from 1965 to 1967 on the health status of 304 children age 12 or younger in a Michigan institution for the retarded. Pediatric assessments revealed that while the children had little acute illness, most of them (250) suffered from one or more physical or sensory defects. Many of these defects had arisen as complications of chronic conditions that presumably had had insufficient attention to prevent deterioration. In the course of the study, 69 percent of the children were referred to specialists for examinations, resulting in more than 600 modifications in their individual care programs.

The investigators noted several obstacles to providing individualized preventive, curative, and rehabilitative health care in an institution for the retarded: (1) a tendency to program for "blocks" of children, (2) the use of the physician's time on an *ad hoc* basis, (3) a shortage of staff and funds, and (4) a failure to maintain close liaison with the providers of care.

The second phase of the study, which took place from 1967 to 1969, sought to document the characteristics of the systems of health services in five institutions for the mentally retarded and the patterns of care they rendered. The investigators found that although each institution reported that multidisciplinary care was its ideal, practices in fact leaned to one or two professional approaches; diagnostic evaluations were rarely followed by long-term plans for treatment; reevaluations tended to include fewer categories of professional assessment than initial diagnostic examinations; and long term patients tended to receive fewer services than recently admitted residents.

On the assumption that all residents of such institutions have a basic right to comprehensive, coordinated, individually planned, continuing health care, Dr. Decker proposes a system that includes provisions for: (1) appraising each resident's present clinical status and level of functioning, (2) establishing individual health and rehabilitation goals and a plan of care for each patient through interdisciplinary resident-care planning conferences, (3) following up to see that the plan is implemented, and (4) reevaluating the plan periodically and making indicated revisions.

The proposed system, with appraisal and report forms, is contained in a monograph, "A System for Planning and Achieving Comprehensive Health Care in Residential Institutions for the Mentally Retarded," by Harold A. Decker, available on request from Dr. Decker, who is now at the Department of Pediatrics, University of Arkansas Medical Center, 4301 West Markham Street, Little Rock, Ark. 72201.

Overweight teenagers

What an overweight teenager needs before he can reduce is "moral treatment"—acceptance by other people, especially those of their own age, on the basis of his own personality and capabilities, according to Werner J. Cahnman, Ph. D., professor emeritus of sociology at Rutgers University. His conclusion is based on a recently completed retrospective study of the sociogenic factor of personality development in six young people who were obese in childhood and adolescence. He found that his subjects experienced a sense of inadequacy and a lack of self-confidence as a result of prejudicial attitudes but responded to social acceptance by losing weight.

The subjects included one male and five females between the ages of 17 and 24 at the time of the study who were interviewed orally and by a written questionnaire about their earlier relationships and attendant feelings. Five had remained overweight, but all had periods of losing weight when they were accepted by their peers.

Each participant reported remembering the incident in late childhood or early adolescence in which he first became aware of being "fat" and therefore "different." All reported feelings of embarrassment, hurt, anger, guilt, and shame. Most of them said they reacted to an insult or comment about weight by increasing food intake and so gaining more weight. Some of the participants reported that their school grades improved in periods of weight loss and declined in periods of weight gain.

Dr. Cahnman points out that overweight adolescents come to believe that others are "right" and that they "deserve" discriminatory treatment. He reports that the young people in his study chose various ways to retreat from society—becoming a comedian, escaping into intellectualism, alternating between

passivity and boisterousness, making exaggerated attempts to please others, manifesting a belligerent "chip on the shoulder" attitude, or refusing to accept criticism and to face facts.

The participants suggested, among other approaches to problems of obesity, an attack on the psychological and sociological causes not merely on its symptoms; education of other teenagers and parents about some of the problems of a fat person; and concrete ways of helping the overweight person gain confidence in himself. One girl said that the biggest problem of overweight people is their own defeatist attitude.

A mimeographed copy of the study findings, including the verbatim comments of the participants, is available from Dr. Werner J. Cahnman, 67-71 Yellowstone Boulevard, Forest Hills, N.Y. 11375. ("The Stigma of Overweight: Six Autobiographies," 20 cents in stamps or coins.)

Marijuana

The use of marijuana cannot be linked to birth defects, chromosomal changes, cancer, or commission of violent crimes on the basis of available scientific evidence, according to the first annual report on marijuana and health, submitted to Congress by the Department of Health, Education, and Welfare February 1. The report points out that although there is a substantial body of information about marijuana, present knowledge is "fragmentary" and much of it is of limited relevance in determining the long-term health implications of use.

The difficulties of obtaining reliable information about the effects are compounded by the fact that varying mixtures of the drug have psychoactive properties "ranging from virtually nonexistent to decidedly hallucinogenic in its stronger forms and at high dosages." The report points out that the form in which the drug is consumed, as well as the behavioral makeup of the user, will also affect the consequences of use.

The report cites studies showing that by the end of 1970, about one college student in seven was using marijuana weekly or more frequently, and 31 percent of all college students had used it at some time; and that while use by high school students has generally lagged behind use by college students, in some high schools one-third to one-

half of the students have experimented with marijuana. The report suggests that the levels of marijuana use among school dropouts are "probably higher" than for high school students. One of the studies cited found that in some communities of hippies, 95 to 100 percent of the residents have used marijuana.

Studies of junior and senior high school students in San Mateo County, Calif., show relatively high levels of marijuana use, with large increases in 1968 and 1969, but a decidedly smaller increase in 1970. The students in the county's seventh and eighth grades used less marijuana in 1970 than in 1969—a statistic the report finds "an interesting change" that "may presage a stabilization of rates or a possible decline in interest among students."

The report warns against the use of any drug of unknown teratogenic or mutagenic properties during the child-bearing years, especially during pregnancy. It also discusses natural and synthetic marijuana, preclinical studies in animals, effects in man, social and cultural concomitants, and research needs. The 176-page report, "Marijuana and Health," may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (\$1.50.)

Health protection

A National Commission on Venereal Disease was created in February by the Department of Health, Education, and Welfare to develop a national strategy for combating gonorrhea and infectious syphilis, estimated to have affected 2 million and 75,000 people, respectively, in the United States in 1970.

The commission will consider the problems behind the rapid rise in the incidence of both diseases in the past year (See CHILDREN, November-December 1970, p. 240); study ways of bringing public health and private medical practitioners who come in contact with the diseases into a closer working relationship; and make recommendations for bringing both diseases under control. A 1968 survey shows that physicians in private practice treat about 80 percent of the cases of VD but make official reports on only about one case in nine.

Bruce Webster, M.D., president of the American Social Health Association, is

chairman of the new commission. Other members include the surgeon general of the United States and representative of professional, medical, and public health organizations and the U.S. Armed Forces.

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The executive board of the American Public Health Association has issued a statement recommending that "safe, accessible abortion services" be "an integral part of comprehensive family planning and maternal and child health care," and be made available at reasonable fees for all who are in need of such services.

The board specifically recommends referral and counseling services for persons seeking abortions; public education about abortion procedures and services; and, when abortion is requested, surgical care by a qualified physician, preferably an obstetrician-gynecologist, and before the end of the third month of pregnancy.

The board stressed the importance of performing any abortion done after the 12th week of pregnancy as an inpatient procedure in a hospital. It also recommended that all abortions be reported to local and State health departments for compilations of statistical data but that confidentiality on individual cases be maintained.

(Address: American Public Health Association, Inc., 1740 Broadway, New York, N.Y. 10019.)

Early education

A home-oriented early childhood education program is the most effective way to reach rural preschool children in Appalachia, according to the preliminary conclusions of a 3-year field test begun in 1968 by the Appalachian Educational Laboratory of Charles W. Va., one of 15 educational research laboratories funded by the U.S. Office of Education.

The program reaches children in remote areas through a mobile classroom, daily television lessons broadcast both commercial and educational channels, and paraprofessional child educators who offer individual guidance to mothers and children during weekly visits to their homes. The cost of the program is less than half as much per child as a conventional kindergarten, according to Roy Alford, Ed. D.,

linator of early childhood education at the laboratory.

About 750 children in West Virginia's Fayette, Mercer, Raleigh, and Summers Counties have participated in the phase of the field test or have served in the control group. Each school year since 1968-69 the primary test group has included about 150 children—divided equally between 3-, 4-, and 5-year-olds. When the previous year's 5-year-olds enter school, a new group of 3-year-olds is enrolled.

A total of 325 television lessons have been shown during the field test. They have been created by the laboratory's curriculum materials team to prepare isolated rural preschool children for the first grade. The team also has developed a weekly newsletter for parents, printed guides for teachers and paraprofessional workers, and visual materials for children.

Tests show that children who have participated in all three components of the program have benefited more than those involved in only two components. Eighty-nine percent of the teachers have reported that they watch television lessons with their preschool children, and almost all use the educational materials distributed by the paraprofessional workers.

The laboratory staff has prepared reports on development of the program,

and will provide television lessons, written materials, and consultation to educational agencies in other parts of Appalachia. (Address: Appalachia Educational Laboratory, Box 1348, Charleston, W. Va. 25325.)

Delinquency treatment

A 16- or 17-year-old delinquent boy who possesses ego strength and personal resilience may profit from confrontation with his peers in a group treatment program but a similar experience may harm a less socially assertive or younger boy, according to a study recently reported by the California Youth Authority. The study was the second part of an evaluation, carried out between 1964 and 1968, of a 90-day preparole program known as the James Marshall Program, at the authority's facility at Norwalk.

The study found that 72 percent (88) of a group of 123 boys who had been in the Marshall program were removed from parole for violations in the 15 ensuing months, compared with 56 percent (69) of the 123 boys in a matched control group who had been in other correctional institutions in California for an average of 7 to 9 months.

The report attributed the higher violation rate of the Marshall group to the extremely high rate of failure among lone offenders—about four-fifths of the

54 "loners" violated parole. However, the significant difference in failure between the Marshall and the comparison groups disappeared when violation rates were recomputed with lone offenders excluded from both groups. The study indicated that loners tend to become more alienated from authority in confrontive situations. It also found that boys who are perturbable, problem bound, and non-assertive were not amenable to the Marshall program.

One group of Marshall boys who had a violation rate lower than the control group—33 percent as compared with 58 percent—consisted of 16 boys who were 16 or 17 years of age and who had had at least two companions when they committed their offense.

For the less assertive, threat-sensitive, or younger boy, the report suggests as an alternative to intensive confrontive treatment, a supportive program emphasizing desired behavior and "normalizing" experiences. It also calls for continuing investigation of the kind of boy—or kinds of boys in combination—who is most likely to benefit from deviance-probing delinquency treatment.

The report of the study, "Amenability to Confrontive Peer-Group Treatment" by Doug Knight, is available as Research Report No. 59 from the California Youth Authority, 714 P Street, Sacramento, Calif. 95814.

guides and reports

TEACHERS AND THE CHILDREN OF POVERTY. Robert Coles, M.D. The Potomac Institute, Inc., 1501 18th Street, NW., Washington, D.C. 20036. 1970. 111 pp. \$2.

Contains suggestions for reaching and helping poor innercity children who are low achievers, based on a study of special school programs in 13 cities; includes drawings by some of the children reviewed.

HEALTH CARE OF CHILDREN: a challenge. Hortense S. Cochrane in collaboration with Theodore DiBuono, M.D. Foreword by Julius B. Rich-

mond, M.D. Syracuse University, School of Social Work, Syracuse, N.Y. 13210. 1970. 85 pp. \$2.50.

Directed to persons engaged in child care services, this pamphlet discusses the health needs of preschool children and the appropriate use of health and medical resources.

INDUSTRY AND DAY CARE: proceedings of a conference. Urban Research Corp., 5464 South Shore Drive, Chicago, Ill. 60615. 1970. 88 pp. \$15.

Proceedings of a 1970 conference of 175 representatives of industry and of

community agencies, early childhood specialists, and day-care center operators, to discuss industry's role in helping to meet the need for day-care services.

ACADEMIC CHILD PSYCHIATRY.

Paul L. Adams, Henry H. Work, and Joseph B. Cramer. The Society of Professors of Child Psychiatry, Children's Mental Health Unit, University of Florida, Gainesville, Fla. 32601. 153 pp. \$3.50.

Consists of 10 papers presented at a Conference of Academic Child Psychiatrists at the University of Florida in 1969, including academic child psychiatry's relation to community mental health centers; clinical services; medical education; research; and teamwork with social workers, psychologists, and others in paramedical professions.

BOOK NOTES

HOW THEY FARED IN ADOPTION: a follow-up study. Benson Jaffee and David Fanshel. Columbia University Press, New York, N.Y. 1970. 370 pp. Cloth \$13.50, paper \$4.95.

This book reports on a study of how 100 adoptive families perceived the development and levels of adjustment of their children 20 to 30 years after the initial placement. Conducted in the mid-1960's for the Child Welfare League of America, the study was designed to identify (1) parents who have reared their adoptive children with relative success, and (2) variables associated with outcome of adoption.

The study was based primarily on interviews with 89 adoptive mothers and 73 adoptive fathers of Caucasian children placed by four New York City agencies between 1931 and 1940. All the children were under 3 years of age at the time of placement.

The research team rated the families on 37 items, reviewed available case records, and interviewed 33 of the "adoptees." At the time of the study, 65 of the adoptive couples were still together; the adoptees (49 boys and 51 girls) were young adults—71 were married and 19 were still living at home.

The families were divided into low-problem, middle-range, and high-problem groups on the basis of overall adjustment of the adoptees as reported by their parents.

The research team was particularly concerned with the way the children were told about adoption and how the telling affected their later adjustment. Parents reported that 44 of the children had "always known" of their adoptive status. For the 56 other adoptees, the study did not find a significant relation between the manner of revelation (source, age of child, circumstances) and outcome of adoption, with one exception. Children who expressed curiosity and anxiety about their biological parents had significantly more problems of adjustment than other children.

Four of the adoptees, now young adults, had never been told that they were adopted. Of these, two were in the low-problem group, and one each in the middle-range and high-problem groups.

The study showed that 9 out of 10 families appeared to retain an enthusiasm about adoption and three-fourths of the couples said they had had no problems specifically related to the child's adoptive status.

The authors recommend that adoptive agencies (1) maintain contact with a cross-sectional sample of adoptive families after final adoption is completed in order to become experts on adoptive family life, and (2) provide counseling and other clinical services to adoptive families.

ADOPTING OLDER CHILDREN.

Alfred Kadushin. Columbia University Press, New York, N.Y. 1970. 245 pp. \$10.

In this book, the author, professor of social work at the University of Wisconsin, reports on a followup study of adoptions of children who were 5 years of age or older at the time of placement. The 91 children, all Caucasian, were placed by the Wisconsin State Department of Public Welfare between 1952 and 1962. As a result of the study, made about 6 years after placement, the author concludes that older children can be placed for adoption with a high probability of success, although he points out that some failures are inevitable.

The study, supported by a grant from the Children's Bureau, involved 49 boys and 42 girls who had been removed from their parents by court action because of neglect or abuse. Subsequently they were placed in foster homes, averaging slightly more than two foster homes per child, before being placed for adoption. Most of the children and adoptive parents adjusted readily to the adoptive placement, and three-fourths of

the adoptions were completed in 2 years.

At the time of the study all the children had accepted a change in last name seemingly without conflict. However, two children had been removed from adoptive homes.

Data for the study were obtained from joint interviews with both adoptive parents about their experience, satisfactions, and dissatisfactions; written comments; and agency records.

The author found that outcome of adoption is more likely to be favorable when the child has been able to develop interpersonal relationships and when adoptive parents have accepted the child and perceived him as a member of the family. Conversely, he found that adoption outcome is less likely to be favorable the older the child, the more temporary placements he has experienced, and the more disturbed behavior he has shown.

The author found that as a whole the children showed a greater degree of psychic health and stability than might have been anticipated from their early lives: 79 percent of the children were rated as capable of developing good or fair interpersonal relationships. Noting that such children, when provided a healthy environment, have been able to surmount the damages of earlier traumatic experiences, he concludes that environment is a major determinant of developmental outcome.

SUMMERHILL: for and against

Nathan W. Ackerman and others. Hart Publishing Co., Inc., New York, N.Y. 1970. 217 pp. Cloth \$7.50, paper \$1.95.

This book of 15 essays by educational psychologists, sociologists, and four other authors reviews the opinions of American educators regarding A. S. Neill's philosophy 10 years after the U.S. publication of his book, "Summerhill: A Radical Approach to Child Rearing." In evaluating the success of Summerhill—English boarding school for disturbed children in which Neill provides an environment of unusual freedom—the authors present a broad spectrum of current ideas about American education.

Rev. John M. Culkin, S.J., finds Summerhill "a holy place." Also "for" Summerhill are Nathan W. Ackerman, Sydney Ashton-Warner, Bruno Bettelheim, Erich Fromm, Paul Goodman, John Holt, Eda J. LeShan, Ashley Montagu,

nest Papanek, Michael Rossman, and Edwin Watson. Several of these authors identify Neill's deep respect for the child as one of the strengths through which Summerhill develops happy, alive human beings.

Only one author—Max Rafferty—is completely "against" Summerhill's methods; he calls the institution "a caricature of education." Two other authors—Louise Bates Ames and Fred Hechinger—express both reservations about the school's anti-intellectualism, and admiration of its headmaster's dedication.

SCENE OF THE BATTLE: group behavior in urban classrooms. Joan I. Roberts. Doubleday and Co., Inc., New York, N.Y. 1970. 441 pp. \$8.95.

Improving the quality of student-teacher relations in classroom groups is basic to stopping the battles that interfere with learning in innercity schools, says the author of this book. A social psychologist, she developed her thesis—but teachers fail because they do not understand or utilize group behavior productively in leading their students—while participating in Project True (Teacher Resources for Urban Education) at Hunter College.

The author presents brief descriptions of more than 400 separate observations of classes in action made by five educators as part of the project in four junior high schools in low-income areas of New York City. Then she discusses the ways teachers function, class structure and its relation to anger and authority in the students, relevant and irrelevant classroom goals, dehumanization of classroom norms, and the stifling effects of educational bureaucracy. She maintains that one of the sources of conflict between teachers and students is the imposition of middle-class goals on children from low-income families.

RECREATION AND LEISURE SERVICE FOR THE DISADVANTAGED—guidelines to program development and related readings. John A. Nesbitt, Paul D. Brown, James F. Murphy. Lea & Febiger, Philadelphia, Pa. 1970. 593 pp. \$14.50.

The book presents guidelines for developing recreation services for chil-

dren and adults in innercity areas along with readings identifying procedures, programs, and suggested activities.

It recommends that public recreation departments—

- Recognize the inability of disadvantaged persons to purchase services, equipment, and other necessities of a good recreation program.

- Use sound procedures for determining the recreational needs of specific communities.

- Evaluate program effectiveness.

- Involve the disadvantaged in every step of programing.

- Respect the value systems of the persons served.

- Integrate staff.

- Publicize staff openings in areas where the disadvantaged live.

- Provide inservice training to increase staff awareness of the needs of members of the disadvantaged community.

The 54 readings provide philosophical, sociological, historical, and contemporary perspectives to many of the points made in the guidelines.

PET-ORIENTED CHILD PSYCHOTHERAPY. Boris M. Levinson. Charles C Thomas, Publisher, Springfield, Ill. 1970. 202 pp. \$9.75.

The use of pets in the treatment of children with emotional difficulties is described in this book by the psychologist who developed this method of psychotherapy. He points out that the pet becomes, in a sense, "the mirror in which the child sees himself wanted and loved not for what he should be . . . but for what he is."

According to the author, the presence of a dog, cat, or other pet in therapy enables the child to project feelings that would be unacceptable if projected toward humans; meets the child's needs for cuddling, companionship, and unconditional acceptance; and provides the child with an opportunity to feel that he is master of his situation. The author warns that assigning a pet to an emotionally disturbed child without at the same time providing for psychotherapeutic intervention can be harmful to both the child and the pet. If, however, the pet is introduced into the family after careful planning and the child is guided into learning how to master the pet, the child also learns how to master his own anxieties.

Through short case histories the author illustrates his thesis that pets are invaluable aides in treating young non-verbal, inhibited, autistic, withdrawn, obsessive, compulsive, and culturally disadvantaged children. He suggests that pets may be used beneficially in residential treatment centers for emotionally disturbed children; in hospitals for children with lengthy illnesses; in training schools for physically or mentally handicapped children; and in day schools for exceptional children.

for parents

THINKING IS CHILD'S PLAY. Evelyn Sharp. E. P. Dutton & Co., Inc., 201 Park Avenue South, New York, N.Y. 10003. 1970. 157 pp. \$4.95.

BABY LEARNING THROUGH BABY PLAY: a parent's guide for the first 2 years. Ira J. Gordon. St. Martin's Press, Inc., 175 Fifth Avenue, New York, N.Y. 10010. 1970. 121 pp. \$5.95.

THE BOYS AND GIRLS BOOK ABOUT DIVORCE. Richard A. Gardner, M.D. Science House, Inc., 59 Fourth Avenue, New York, N.Y. 10003. 1970. 158 pp. \$7.95.

YOUR CHILD AND HOUSEHOLD SAFETY. Jay M. Arena, M.D. Chemical Specialties Manufacturers Association, Inc., 50 East 41st Street, New York, N.Y. 10017. 1970. 20 pp. 25 cents.

HELP FOR YOUR TROUBLED CHILD. Alicerose Barman and Lisa Cohen. Public Affairs Committee, Inc., 381 Park Avenue South, New York, N.Y. 10016. 1970. 24 pp. 25 cents.

ADVICE TO PARENTS OF A CLEFT PALATE CHILD. Donna K. Wicka and Mervyn L. Falk. Charles C Thomas, 301-327 East Lawrence Avenue, Springfield, Ill. 62703. 1970. 57 pp. \$3.25.

THE WORKING MOTHER'S GUIDE TO HER HOME, HER FAMILY AND HERSELF. Alice Skelsey. Random House, 201 East 50th Street, New York, N.Y. 10022. 1970. 247 pp. \$6.95.

IN THE JOURNALS

Family stability

The majority of black adults and children in America are in statuses indicative of family stability—that is, most adults are currently married, most families are husband-wife families, and most children are legitimate and live with both parents, according to a study of the trends from the 1890's to the present reported by Reynolds Farley and Albert I. Hermalin in the February 1971 issue of *American Sociological Review*. ("Family Stability: A Comparison of Trends Between Blacks and Whites.") The authors, associate professor of sociology and research associate, respectively, at the University of Michigan, find that in every comparison between blacks and whites, the proportion of persons in the status indicative of family stability is greater among whites.

However, the comparison from 1890 to the present suggests that the relative stability of black families, as indicated by the proportion "currently married" has remained steady. The increasing differences between whites and blacks during this time have been largely due to an increase in the proportion of whites currently married. In general, trends in black and in white families are the same—that is, there has been an increase in divorce and a decrease in widowhood.

The authors attribute the increase in the number of female heads of black families at least partly to the fact that many women are now economically able to maintain their own households instead of being counted as "other relative" in some other household. Although this is a general trend in both white and black families, it is more marked in black families.

Study data show that currently married men of both races have higher socioeconomic status than do single, widowed, divorced men or men whose spouses do not live with them. More-

over, differences between categories of marital status within the same race are much smaller than differences between races. The authors conclude that family instability is associated with somewhat lower levels of life chance variables (education, occupation, and income).

Divorce and children

"It is a truism today that parents should be honest with their children, but parents apparently do not always extend this precept to being honest with their children about divorce," says Paul Bohannon, Ph. D., in an article in the January-February 1971 issue of *The Single Parent*. ("The Six Stations of Divorce.") The author, an anthropologist at Northwestern University, maintains that children should be told ahead of time about the coparental aspects of divorce—including custody, visitation, and the new division of labor in the household—so they can know what to expect and so adjust more easily.

Such aspects of divorce bring problems that are long-lasting and difficult, the author explains, because the child's parents—while divorced from each other—are not divorced from the child.

Since children in divorce miss some of the family culture they would have learned by living in an unbroken healthy home, the author suggests that they be taught purposefully about the companionship, sexual, coparenting, and domestic aspects of marriage. This should be done, he says, without bitterness or hostility and without denigrating or idealizing the absent parent.

Citing the traditional and popular belief that divorce is "bad for children," the author points out that "actually, we do not know very much about it." Some children deal with the tensions of divorce by turning to delinquency, he observes, while others react with supercompliance. "The tensions in divorce certainly tell on children," he

says, "but the answers the children find are not inherent in the institution of divorce."

The author lists six overlapping experiences that occur in every divorce: emotional, legal, economic, coparental, community, and psychic experiences separation. He suggests that they are "more painful and puzzling as personal experiences" because society is not yet equipped to handle any of them well.

Parents and TV

The parental role in the child's television experience goes far beyond switching the channel or shutting the set when the child is watching possibly harmful program, according to an article by Norman L. Paul, M.D., the March 1971 issue of *Childhood Education*. ("Invisible Factors in a Child's Reaction to Television.") How the child reacts to violence in a TV program, the author says, may be conditioned much by the quality of the parent-child dialogue and the child's feelings about himself and his various fears as to what goes on in the program.

Pointing to the confusion of fantasy and reality in the young child's mind, the author stresses the importance of helping the child bridge the gap between the two, not only by knowing what is watching but by helping him to see it in perspective by talking with him about what he sees.

Because the real life of a real family lacks "the rosy and rarified tranquility of a situation comedy series and the excitement of an adventure series," parents need to demonstrate the value of the real situation by encouraging communication and the frank expression of feelings, the author maintains.

He suggests that long-term effects of the patterns of unreality that come to a child through television may be more damaging than immediate aggressive response to a violent scene: "What happens when the child becomes inured to terrifying and violent scenes on television? . . . Will violence in the real world seem more acceptable and casual and thus decrease the concern individuals have for each other?"

Such questions, he says, bring us back to the parents' role "in providing a path and a reality input." Granting the need for better programming, he maintains that "it is the communication between parents and children to which

we should be addressing our primary attention and concern."

White and black

Child welfare workers, especially white workers, have to be acutely aware of how they work with black children today, says Crawford E. Burns, L.S.W., director of community services at the Children's Village in New York City, in the February 1971 issue of *Child Welfare*. ("White Staff, Black Children: Is There A Problem?") He maintains that the mistrust of whites by black children is not a new problem, but is one that is manifested openly today instead of being suppressed.

Pointing to the tendency of children in institutions, regardless of race, to resent authority and "seek out the cracks in each worker's defense mechanisms," the author says that many black children today have learned how to manipulate the guilt feelings their white workers have about the injustices suffered by black people. He warns white institutional workers against practicing "discrimination in reverse" and not setting the limits that children need and want. Children are children first and "black children" second, he says.

Black children must be helped to express their own group identity, the author says. However, he points out

that the term "black identity" is an oversimplification, meaning something different to each black person, depending on his own background, personality, and family attitudes.

The author stresses the importance of examining one's pet prejudices, "racial or otherwise," in working across racial lines. As a medium for such examination he advocates interracial sensitivity training groups for agency staffs. Such groups, he says, can help white and black workers to achieve a better understanding of one another as well as the children to whom they must relate. He also recommends group discussions between staff members and children.

READERS' EXCHANGE

GALLAGHER: the black experience

I was impressed by Ursula Gallagher's article because it provides a clear picture of the national situation in an area of urgent need, and suggests some directions for solving the problem. "Adoption Resources for Black Children," CHILDREN, March-April 1971.) However, at our agency, Homes for Black Children, we do not believe our success has been determined by recruitment techniques. Naturally families had to be recruited, but recruitment was easy for us because the black community could identify with the name of the agency. Being a black agency was also helpful in reducing anxiety in potential adoptive parents, particularly when they found a predominately black staff. This lessening of anxiety enabled them to stay in the process and use the process more effectively. The black community in Detroit does not see Homes for Black Children as a "white man's resource."

My point is that established agencies that have not been successful in obtain-

ing and keeping black applicants are likely to find increased recruitment a waste of time and money. A great deal of the recruitment that has been done for black families has been aimed at eliciting sympathy. This is completely ineffectual. Identifying the simple truth that black families have always "adopted" at a much high rate than white families is important. The fact that these arrangements have normally been informal indicates more need for education than for recruitment. It also indicates a need for change within agencies.

Suggesting a need for change in agencies supports Miss Gallagher's statement that new methods of approaching black families must be developed. I believe that large percentages of people involved in administering, planning, and delivering adoption services are not fully aware of the meaning of the black experience in America. It is completely unrealistic to expect black families to respond to the agency, regardless of process, as white families respond.

Agencies must reach out to recruited families with interest and support or the majority of black families recruited will be lost. Most white families expect to be approved for placement and have great difficulty understanding or accepting not being approved. Many and probably most black families anticipate rejection and frequently withdraw their applications to avoid rejection. This difference makes the need for different methods obvious.

The problem of black children waiting for adoption is one of the most urgent social problems in America. We are pleased that the Children's Bureau is helping to identify the magnitude of this problem, and hope that it will continue to seek solutions.

Clarence D. Fischer
Administrative Director
Homes for Black Children
Detroit, Mich.

A slighted resource

The title of Ursula M. Gallagher's article, "Adoption Resources for Black Children" implied many potential adoptive resources for black children.

Miss Gallagher is to be commended for the excellent job of compiling and presenting the multifaceted problem of adoption placements for black children. Her article provides an excellent resource overview of adoption services

and innovations. However, it did not entirely fulfill my expectations.

My expectations were based on my view of the Children's Bureau as an advocate for children and on my experience in an agency which subsidizes families so that they can adopt children. In reading the article I felt that Miss Gallagher's treatment of subsidized adoptions did not give this resource the importance that it deserves. I do not mean to negate the effectiveness of the newer recruitment techniques, the liberalized requirements for adoption nor the practice of bringing the service to the community as did the Los Angeles County Department of Adoptions when it opened an office in Compton, Calif. However, there is a fact of life that heavily influences the ability of any family, particularly a black family, to adopt—*economics*.

A study reported in an unpublished master's thesis, "Adoption and the Middle-Class Negro," by G. Kennedy et al., presented to the faculty of the School of Social Work, University of Southern California in June 1967, found that many black families felt that educational and cultural goals for their children would be limited if they accepted economic responsibility for a larger family.

Maybe it was not within the scope of Miss Gallagher's article to give more attention to subsidized adoption. However, I would like to see an article in *CHILDREN* that treats this topic specifically. By virtue of the magazine's position of national leadership as an advocate for children, such an article would give impetus to more widespread use of subsidies to help families adopt black children.

Shirley L. Ross
Los Angeles
County Department of Adoptions
Compton, Calif.

PRESCOTT and JONES: A fair contrast?

In experience, observations, and thinking I am in basic accord with the points made by Elizabeth Prescott and Elizabeth Jones in the March-April issue of *CHILDREN*. ("Day Care for Children—assets and liabilities"). However, in reading the article, at times I had the feeling that they unintentionally were contrasting a model family with a mediocre center. To be sure most day-care centers are mediocre, but alas,

most of the children attending them come from anything but ideal families.

Certainly, group day care is no panacea for the deprived, but the essential elements that can be part of it should be stressed.

For instance, teachers who care about the children are a necessity where children are to be in group care all day. In addition, they must have skill, knowledge, and self-awareness if they are to be effective. We Americans tend to think that developing the intellect is the only aspect of education that takes training. That perceptiveness, imagination, and self-discipline are involved in the effective teaching of young children is too often overlooked. Teachers must have a natural aptitude for acquiring these skills, but developing them takes time.

In this day when many people hope that the provision of day care on a mass scale can become a profit-making venture, the need for smallness, informality, and flexibility in a day-care program cannot be overstressed. Big buildings are not for little children.

The problem of how to promote the kind of day care that supports rather than subdues the human spirit is a serious one. Neither the public at large nor those in power have accepted the cost of good day care, and the ultimate price of poor day care is completely overlooked. The tendency is to believe that the day care of children should be cheap—and I use the word advisedly. There is little appreciation of the worth of a skillful nursery school teacher, nor of the need for small groups.

We must somehow promote stronger conviction in those responsible for the young. Individualization and privacy can be achieved, even in group settings, where there is a will. For instance, children can be separated by screens at naptime and can be allowed to play quietly if they do not need the sleep.

There can and should be more creative experimentation. The Day Nursery Association of Cleveland has a small but excellent family day-care program. It costs as much as good group care and has educational and social elements built in. It has as well flexibility, nearness to home, and care for children of widely different ages. It has opened wider horizons and career opportunities to women with a capacity for mothering who can now work in their own homes.

The basic problem in building a day-

care program is to arouse enough concern to assure that balance can be achieved. I would agree with the author that good parent-staff communication can lead to creative ideas and is imperative.

Eleanor M. Host
Executive Director
Day Nursery Association of Cleveland
Cleveland, O

collected readings

PSYCHOLINGUISTICS: selected papers. Roger Brown. The Free Press, 866 Third Avenue, New York, N.Y. 10022. 1970. 392 pp. \$8.95.

TROUBLED CHILDREN IN A TROUBLED WORLD. Edith Buxbaum. International Universities Press, Inc., 239 Park Avenue South, New York, N.Y. 10003. 1970. 341 pp. \$10.

THE BLACK FAMILY: essays and studies. Robert Staples. Wadsworth Publishing Co., Inc., 10 Davis Drive, Belmont, Calif. 94002. 1971. 393 pp. \$4.95.

POPULATION, EVOLUTION, AND BIRTH CONTROL. Garrett Harcourt, editor. W. H. Freeman and Company, 660 Market Street, San Francisco, Calif. 94104. 1969. 386 pp. Cloth \$2.95, paper \$2.95.

LIFE HISTORY RESEARCH IN PSYCHOPATHOLOGY. Edited by Merrill Roff and David F. Roff. University of Minnesota Press, Minneapolis, Minn. 55414. 1970. 321 pp. \$10.

THE DISADVANTAGED CHILD. L. Frost and Glenn R. Hawkes, editors. Houghton Mifflin Co., Educational Division, News Bureau, Tremont Street, Boston, Mass. 02118. 1970. 499 pp. \$5.95.

FROM CHILD TO ADULT: studies in the anthropology of education. J. Middleton, editor. The Natural History Press, Doubleday & Co., Inc., Park Avenue, New York, N.Y. 10017. 1970. 355 pp. \$8.95 hardbound, \$4.95 paper.

U.S. Government Publications

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PLANNING OPPORTUNITIES FOR DISADVANTAGED YOUTH: a planning and coordinating guide. President's Council on Youth Opportunity in cooperation with HEW, OCD, Children's Bureau. 1971. 80 pp. 75 cents. This publication is a manual for planning and coordinating resources to provide children and youth opportunities for adventure and experience in out-of-town camping. It also provides stories of Federal resources to help in designing and operating such programs for disadvantaged children and youth.

IDENTITY IN A TROUBLED WORLD: report of a conference, June 20-21, 1968. HEW, OCD, Children's Bureau. CB Publication 469. 70. 60 pp. 65 cents.

This publication summarizes the 2 days of discussions between 25 young

W refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; PHS, to Public Health Service; SRS, to Social and Rehabilitation Service; OE, to Office of Education.

people and adults of various racial and ethnic backgrounds brought together by the Children's Bureau to probe the difficulties young people have today in achieving an identity that makes sense to themselves. It presents many different points of view and one point of unanimity: youth wants "in" as a contributing member of society.

CHILD WELFARE TRAINING GRANT AWARDS: fiscal year 1970. HEW, SRS, Community Services Administration. 1970. 11 pp. Single copies free from CSA.

Lists the 77 schools of social work and 19 other institutions of higher learning awarded teaching grants (totaling \$2,876,854), traineeships (\$2,823,119), or grants for short-term training projects (\$99,968) during fiscal year 1970.

WIN FOR A CHANGE: through the work incentive program. U.S. Department of Labor, Manpower Administration. 1970. 26 pp. 60 cents.

Describes the work incentive program for recipients of aid to families with dependent children (AFDC) by

following a participant through training to job placement and points out that the major obstacles to greater achievements have been difficulty in providing enough training spots for all the people in the AFDC program who want to prepare for employment and the shortage of good child care facilities.

AN ANNOTATED BIBLIOGRAPHY ON CHILDREN. HEW Department Library, for the White House Conference on Children. 1970. 75 pp. Free from the White House Conference on Children, Box 19, Washington, D.C. 20044.

Lists and annotates 500 recently published materials related to topics for the 1970 White House Conference on Children—individuality, learning, health, parents and family, communities and environments, and laws, rights, and responsibilities.

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july • august 1971

White House Conference on Youth
the hospitalized adolescent
improving care for the mentally retarded
foster parents' conference



CHILDREN

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A young delegate makes a point at a workshop of the White House Conference on Youth, as an adult looks on. The recent conference, held near Estes Park in the Rocky Mountains of Colorado, brought together almost 1,400 young people and adults from every part of the country to discuss the problems of youth and the Nation, and to make recommendations to the President. For some impressions of this conference, see the article beginning on the next page.

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YOUTH HAS ITS SAY IN THE ROCKIES

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SIDNEY ROSENDORF

● Nearly 8,000 feet up in the Rocky Mountains in a setting of tall Ponderosa pines and falling snow, amid a kind of good-natured confusion, a new kind of conference for the youth of this Nation took place from April 18 to 22, 1968.

Any way you look at it, the White House Conference on Youth was an extraordinary event. For the first time, departing from the traditional White House Conferences on Children and Youth, the President convened a separate conference on youth, where the young people called the shots, determined the issues, and made the recommendations for action.

For 4 days, at a remote YMCA conference center near Estes Park, Colo., 915 young people aged 15 to 24, met with 473 adults to grapple with 10 major concerns of young people and the Nation: foreign relations; environment; race and minority group relations; drugs; education; the draft and its alternatives; poverty; legal rights and justice; economy and employment; and values, ethics, and culture.

To deal with these tough issues, the 1,388 delegates plodded through knee-high snowdrifts at the conference site to meet in small and large group wood cabins and lodges with names like "Mum Hall," "Chickadee," and "Wind River Lounge." In an informal setting, the youth and adults worked together, argued together, ate together, and listened to the Drug Task Force Rock Band well into the night.

Some newspaper reporters at the conference seemed skeptical about its makeup and accomplishments, but this observer was impressed by:

● The diversity of the delegates. "This conference is made up of participants who are decidedly un-



ended," Stephen Hess, national chairman of the conference, had announced at the opening session. A broader range of people could hardly be imagined. There were young people from high schools, colleges, Corps centers, jobs in industry and the professions, and the Armed Forces, as well as school dropouts and unemployed youth; young people from every ethnic and income group and every State and territory; and youth of every shade of opinion, including the activist president of the National Student Association and the conservative president of the Young Americans for Freedom.

Among the adults were business and labor leaders, college presidents, members of Congress, officials of federal agencies, mayors, State legislators, and judges—all chosen, as Mr. Hess put it, "because they represent power."

- The give-and-take among youth and adults. Although opinions were strong, the young people and adults did a remarkable thing: they *listened* to one another. In the smaller workshops, each seemed content to hear the other fellow's viewpoint. In the large general sessions, the delegates shouted down militant demonstrators and insisted that everyone who wanted to speak have a fair hearing. Often, members of opposing interest groups—and of different generations—found themselves in surprising agreement.

On other occasions, however, differences were sharp. The issue of Indochina, for instance, seemed to divide the delegates more than any other. At the final session of the conference, a majority of the delegates voted for total U.S. withdrawal by the end of

this year. But a large group of delegates—39.5 percent of those voting—supported a minority resolution endorsing Vietnamization and a steady but gradual withdrawal.

- The intense interest and concern of the young delegates. They sat by the hour drawing up recommendations, arguing points, and taking a break only for quick meals. Many worked late at night to meet the deadlines for resolutions. Most showed an earnest desire to deal with the Nation's major problems and to help solve them within our present social framework. Adult observers found them bright and alert, although often lacking in information about the ways of business and government.

- The advantages of the remote conference site. The mountain setting of the conference, which had been widely criticized before the sessions began because of its isolation, proved to be an asset. The young men and women in dungarees and sweaters seemed relaxed and at home in the plain, weather-beaten buildings of the YMCA camp. The unexpected heavy snow, which confined everyone to camp, drew the young people together, so that they spent more time in the workshop sessions. As they tramped and laughed through the drifts, there was an air of fun and shared experience that might have been missing in a large city.

- The strong desire that the conference be followed up. "What scares me is that nothing will come of this," said a girl in a task force workshop on poverty. "We'll come up with many recommendations, and

nothing will happen." The young people and many of the adults were deeply concerned that the conference be followed up during the years ahead. "We want our own representatives who will follow through in Washington . . . we don't want this to die," I was told. A student said, "We'll want to know what has been done 1, 2, and 3 years from now," and a college instructor asked, "What can the universities do to help?" At the closing session, a resolution proposing a similar conference every 4 years passed overwhelmingly.

At the opening session on April 18, Elliot L. Richardson, Secretary of Health, Education, and Welfare, told the delegates: "We want to know your concerns, and we will set up mechanisms through which Federal agencies can investigate your recommendations." He pledged to review the conference proposals promptly, to present them in preliminary form to the President at the next Cabinet meeting, and to set up a reporting procedure for followup. At the same session, Mr. Hess announced that the President had requested an appropriation of \$304,000 to underwrite activities to follow up this conference and the White House Conference on Children held in Washington, D.C., in December 1970.

Organizing the conference

Selecting the delegates, planning the conference, and organizing the program involved months of work by the conference staff and many others.

In preparing the conference program, the staff sought the ideas and advice of many persons, including youth and adult members of State Committees on Children and Youth, executives of national voluntary organizations and youth groups, and authorities in education, business, and government. Ten preliminary task forces were set up, one for each of the 10 key issues selected for the conference; each task force consisted of an adult and a youth cochairman, plus seven youths and three adults. The members of the task forces were selected by the cochairmen from nominations submitted by State Committees on Children and Youth, national organizations, Federal agencies, Congress, and other groups. In addition to helping plan the conference, these task forces pre-

pared the advisory background reports that we sent to the delegates in advance as a basis for discussion at the conference.

To make this what Mr. Hess called "the most representative conference ever held on American youth" the 1,000 young people invited as delegates were chosen to reflect the Nation's youth population geographically, racially, economically, and educationally. Census figures for ages 14 to 24 were used as guides in the selection.

A breakdown released by the conference staff showed that 53 percent of the youth delegates invited were male and 47 percent were female. About 35 percent were in college and 39 percent in high school; 35 percent were either working, taking vocational courses, or looking for work; and 4 percent were servicemen on active duty. Geographically, the selection proportionately followed population figures for various regions of the country. Every racial and ethnic group was substantially represented, but there was a 10-percent overrepresentation of minority groups as a whole to assure them a strong voice at the conference. Of the 1,000 young people invited, 15 percent were chosen from names submitted by State Committees on Children and Youth, 15 percent from nominations by national voluntary organizations, and 42 percent from nominations by others—including members of Congress and the preconference task forces.

The 500 adults invited as delegates were selected from names suggested by business and institutional leaders and by the preconference task forces.

Down to work

Because of this careful advance planning, the delegates were able to get down to work immediately when they arrived at Estes Park. They met first in enlarged task force groups, each organized around one of the major subject areas. Each of these groups, consisting of approximately 100 young people and adults, then broke up into workshops—smaller discussion groups charged with developing specific recommendations to be submitted to the President.

As these discussion groups met, it soon became evident that the delegates from racial or ethnic minorities—both adults and young people—had concerns of their own and wanted to take them up in their own way. The Task Force on Race and Minority Group Relations split into a number of caucuses—including Black, Asian, Spanish-American, European-American, American Indian, and "nonethnic,"

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SOME SIGNIFICANT RECOMMENDATIONS of the White House Conference on Youth

The following, in brief, are a few of the many recommendations to be sent to the President:

Strongly endorsed by vote at the final session:

FOREIGN RELATIONS. Immediate ending of all U.S. air, naval, and ground operations in Indochina, and total withdrawal of all American military forces by December 31, 1971.

ENVIRONMENT. A national effort to improve the environment in the inner cities, with local citizen participation, planning of housing programs, and development of alternatives to an automobile-based transportation system.

LEGAL RIGHTS AND JUSTICE. Lowering of the age of majority to 18, so that young people will not only have the vote but also the full privileges of adult citizenship, including the right to marry and make contracts without parental consent.

EDUCATION. Allocation of 25 percent of the Federal budget to education, which now receives only 3.6 percent of the national budget.*

DRUGS. Legalization of marijuana, with Government control of the importing, distribution, sale, and purity of the drug.*

Not submitted to the final session for a vote:

ENVIRONMENT. Establishment of a National Environmental Corps in which young people could be employed as an alternative to military service.

DRUGS. Possession of drugs for personal use no longer to be considered a crime.

Vigorous prosecution of the illegal sale and the manufacture for sale of drugs, and a program to eliminate large-scale importing and distribution operations.

EDUCATION. Participation in educational policy decisions by high school and university students through

representation on school governing boards and in government agency panels.

Adoption by high schools and universities of a code of student rights, responsibilities, and conduct that clearly defines such rights as free speech, demonstrations, dress, etc.

DRAFT AND NATIONAL SERVICE. Elimination of the draft and the substitution of an all-voluntary Army.

Declaration by the President of an amnesty for all draft violators and exiles.

POVERTY. Replacement of the present welfare system by an income program that guarantees a decent standard of living to every American—the benefit level to be no less than the standard of adequate income set by the Bureau of Labor Statistics, currently \$6,500 for a family of four.

Nationalization of the coal industry and abolition of strip mining.

LEGAL RIGHTS AND JUSTICE. Protection of the legal rights of juveniles through an expanded defender system for youth and the education of young people in juvenile law.

A comprehensive review of the military legal system, with revisions where needed to protect the rights of servicemen.

ECONOMY AND EMPLOYMENT. Mobilization by the President of a nationwide effort by government, business, and labor to provide jobs this summer for youth.

Establishment by the Federal Government of a National Educational Opportunities Bank to lend money to students for higher and vocational education.

A national program of public service employment that would offer full- and part-time job opportunities to youth.

*Submitted by a caucus.

st, a group primarily composed of whites. Each of these groups met separately and prepared its own report for the President. Soon other splinter groups formed and made themselves heard. Before the conference ended, there were statements from a Women's caucus, an Appalachian Youth Caucus, a GI and Veterans' Caucus, a Socialists' Caucus, a Free Enterprise Caucus, and many others. Reflecting the attitude of many minority delegates in all task forces, a mem-

ber of the race task force told the conference: "We reject the concept of the melting pot. We must redefine America as a Nation based on a true cultural pluralism."

On April 20, each task force and caucus assembled to vote on its final recommendations. Each was given the option of placing all, some, or none of its recommendations on a ballot for secret vote by the delegates at the closing plenary session of the conference. Pro-

posals not voted on at this session were to be submitted to the President with the others. Of the 10 task forces, only four—foreign relations, environment, legal rights and justice, and values, ethics, and culture—voted to put some of their proposals on the ballot. The others decided that their recommendations required more careful consideration than was possible at such a session.

The conference came to a roaring climax at the closing plenary session held on the afternoon of April 21. In Longhouse, a vast, high-ceilinged hall, about 1,200 youth and adult delegates met for 5 hours to hear final pleas, arguments, and rebuttals, and to vote on a number of proposals on the ballot. Representatives of the task forces and caucuses which did not put their recommendations to a vote described their proposals to the assembled delegates. (For a listing of some of the major recommendations of the conference, see the box on page 125.)

The enthusiasm of the young delegates was documented by a press survey of the youth delegates who attended this final session. It showed that, of 538 young people who filled out the questionnaire, 13 percent thought that the conference had been highly successful in achieving its purpose; 60 percent, that it had been somewhat successful; and 15 percent, that it had been unsuccessful.

Followup

As the conference closed, the attention of the delegates was focused on ways to implement its recommendations. The task forces and the caucuses elected

representatives to a followup committee. Six other members were selected by the White House Conference staff. This 40-member committee will meet with Government officials in Washington during the coming year and will issue a report to all delegates one year after the starting date of the conference. Because of the strong interest of the youth delegates in followup, it is likely that many of these young people will also form committees and develop additional means of communication.

Some national voluntary youth-serving organizations plan to discuss the recommendations at their national conventions. Congressional committees may hold hearings on these proposals.

After the resolutions are presented to the President, the conference proceedings will be published and sent to the appropriate Government officials, business firms, and to educational and other institutions throughout the country.

When the recommendations of the 1971 White House Conference on Youth are presented to the President, they will be introduced by a special preamble written by members of the Values, Ethics, and Culture Task Force. At the tumultuous final session of the conference, Karen Rux of Durham, North Carolina, stood up to read this preamble to the assembled delegates:

"The high ideals upon which this country was ostensibly founded," she read, "have never been a reality for all peoples from the beginning to the present day. . . . The greatest blemish on the history of the United States of America is slavery and its legacy. . . . It is time now finally to affirm and implement the rights articulated in the Declaration of Independence and the Constitution."

After describing the shortcomings that have undermined the ideals of the Nation and the fears and divisiveness that exist today, the preamble continued: "We recognize further that while youth is often more receptive to change, they are not alone in desiring change. We affirm our kinship with persons of good will in all generations We are aware of our responsibility to fight for the rights of all people"

"Out of the rage of love for the unimplemented principles we here assert, we challenge the Government and power structures to respond swiftly, sensitively, and constructively to our proposals. We are motivated not by hatred, but by disappointment and love for the unfulfilled potential of this Nation."

As Miss Rux finished reading, more than 1,000 young people and adults got up on their feet and cheered.

When a heavy snow fell, the U.S. Army rushed up parkas and boots to lend to the delegates. Here, they line up to get boots.



THE HOSPITALIZED ADOLESCENT

JOHN E. SCHOWALTER
JUDITH D. LORD

Over the past 20 years, the idea that adolescents need special medical attention has been attracting more and more supporters. In the early 1950's, Roswell Gallagher, M.D., was instrumental in the establishment at the Boston Children's Hospital of the first outpatient clinic for adolescents in this country and the first training program for physicians in the subspecialty of medicine for adolescents.¹ Emphasis was placed on the importance of the psychological as well as the physical changes that occur during adolescence. Physicians trained in this program eventually developed other outpatient clinics and other training programs. Adolescents requiring hospitalization, however, were usually placed either with adults or younger children.

In 1965 the Department of Pediatrics at the Yale Medical School, in great need of more beds, was promised the use of one floor of the soon-to-be-opened Hunter wing of the Yale-New Haven Hospital. Drs. Charles D. Cook, Albert J. Solnit, and Fred Rodgett formulated a tentative plan for the development of a program of adolescent services to include both inpatient and outpatient care. The Children's Bureau allocated Federal funds under the maternal and child health program for staffing the unit. Budget provisions were made for a pediatric director, a child psychiatrist, and a social worker to serve both in the clinic and on the adolescent ward, and for a recreation worker to be assigned to the ward. The service has also received financial support from the U.S. Public Health Service and from the Connecticut Department of Health.

This article will for the most part deal with the psychological aspects of the experience.

First, a word is in order on the psychological impact of illness and hospitalization on patients in general and on adolescents in particular. Persons in the health field have long noted that illness causes people to regress. Adults may become childishly demanding or begin to dwell almost exclusively on their youth; children may resume bed wetting, thumb sucking, or baby talk.

All too often hospitalization is a depersonalizing experience that accentuates such regressive tendencies. The patient leaves home and loved ones for an unfamiliar setting where many of his personal possessions, including his clothes, are taken from him. Feelings of powerlessness and dependency are common among hospitalized patients, especially those who need help with such elementary functions as eating, toileting, or moving about. The sense of helplessness is accentuated by the fact that the patient has little control over his illness, its treatment, or outcome and must accept the decisions of the staff.

Adolescents are especially vulnerable to the regression and feelings of depersonalization fostered by illness and hospitalization. The primary developmental task in adolescence is to attain independence. When an adolescent who has just begun to make decisions for himself is hospitalized, he finds the enforced passivity and loss of autonomy very humiliating. Moreover, the rapid and drastic physical changes experienced in adolescence make the adolescent especially sensitive to his body. Loss of body control, frequent examinations, and embarrassing physical procedures tend to undermine his dawning sense of pride in his own sexual identity. Adolescence is the time of life when beauty and strength are most

highly prized. Therefore, a debilitating illness often brings feelings of shame and loss of self-esteem.

The adolescent ward

Hunter 4, the 21-bed adolescent unit at the Yale-New Haven Hospital, was established with the needs and tasks of adolescence very much in mind. Since its beginning, the staff has tried to promote its development as a model unit for teaching and research and at the same time to cultivate a ward atmosphere that will reduce the deleterious aspects of hospitalization as much as possible. Walter Anyan, M.D., is medical director of the ward; general day-to-day medical care is provided all patients by a pediatric assistant resident and two pediatric interns. Private physicians and faculty members of the Yale Medical School from the various specialties act as consultants.

A fellow in child psychiatry is assigned to the unit each fall for a 1-year term by Yale's Child Study Center. The house medical staff, nurses, nurses' aides, and dietary workers are provided by the hospital. A half-time teacher is assigned to the ward by the New Haven school system, and about a dozen volunteers from Yale College donate their time and services.

At Hunter 4, boys and girls occupy separate rooms but share the recreational facilities. With the exception of obstetric patients, being in the adolescent age range is the sole criterion for admission. The unit is geared to care for the physically ill. Nonviolent adolescents with psychiatric problems are admitted to the floor, but more than two psychiatric patients usually cause ward disruption. Assignment to a single or multiple bedroom is based on medical or temperamental need rather than ability to pay.

Since Hunter 4 was among the first adolescent wards to be established in this country, the staff had to be guided by its own observations and its knowledge both of adolescent behavior² in general and the general psychological effects of hospitalization. Its basic approach, aimed at making hospitalization as positive an experience as possible, has been through group meetings. The psychiatrist and the social worker conduct three separate meetings each week, one for patients, one for the entire staff, and one for the nurses only. These meetings represent an attempt to expedite understanding between patients and staff, and to encourage communication between the members of each group.

There are, however, about 60 to 90 formal psychiatric consultations regarding the unit's patients.

Very few are suffering primarily from a psychiatric disorder. Most of those referred for consultation have entered the hospital with a physical ailment that either: (1) Produces, or (2) has perhaps been produced by, psychological distress. Patients undergoing disfiguring surgery, wearing body casts, having chronic or fatal illnesses, fall into the first category. Consultations regarding them are aimed at helping them cope with the stress. In the distress produced illnesses, such as asthma or colitis, the patient and his parents are interviewed in an attempt to assess the emotional components that have triggered the attack. Most of these psychiatric consultations are a joint venture by the fellow in child psychiatry and the ward social worker, who generally meets with the parents, in collaboration with the patient's pediatrician. For example, a patient hospitalized for a suicide attempt is interviewed by the child psychiatrist. The parents are interviewed by the social worker and the child psychiatrist. During hospitalization, which might be days or weeks, the pediatrician with his medical information, the nurse with their clinical observations and the child psychiatrist and the social worker with data from their interviews meet regularly to plan the patient's hospital care and aftercare.

Patients' meetings

Attendance at the patients' meetings, as at other ward meetings, is voluntary. The size of group fluctuates from week to week, with an average attendance of five, in addition to the staff member conducting the meeting. Children come in street bed attire, on foot or in wheelchairs, in beds or stretchers. One 11-year-old girl, stretched on a frame by rods implanted in her ankles and a steel ring pinned to her shaven head, attended regularly several months.

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Since the average hospital stay is 5 days, there is a continuing group as in group therapy. The character of the sessions varies with the age and articulateness of the participants. The degree of the patients' involvement in the discussion determines the length of the meeting; the average meeting lasts about an hour. At the outset, the patients give their names, ages, and, if they do not object, the reason for their hospitalization. The staff members introduce themselves and explain that wards for teenagers are there, that the staff is constantly trying to improve the ward they are in, and that knowledge of patients' likes, dislikes, and apprehensions helps the staff members provide better care.

The young people bring up a variety of subjects at the meetings. The most frequent are food, ward atmosphere and routines, surgery, and death. Patients have also used the sessions for relieving their hostile feelings toward parents, siblings, and others. Food, however, remains the topic that is most frequently discussed. The inevitable consensus of the young people is that hospital food, with its repetition of such standard items as milk and jello, is very poor or indeed. Food to a young patient means nurturing as well as nutrition. Through it he attempts to satisfy his longing to be mothered.

While the patients often displace their angry feelings about hospitalization onto the food, they rarely express direct dissatisfaction with the ward staff. When they do, nurses are more frequently the targets than doctors, and usually the complaint is made under the guise that it is on the behalf of a supposedly ill-treated roommate. A not unusual fantasy among young patients is that proper mothering could have prevented illness. Since nurses, like food, symbolize mothering, the nurses become a target for hostility. The tendency of patients to avoid directing anger at doctors perhaps reflects their fear of retribution from the persons in whose hands their fate resides.

Ward routines are constantly reviewed in the patients' meetings. Suggestions made or supported by the patients have resulted in a number of changes, including the installation of telephones in each room, the acquisition of a jukebox, pool table, and pinball machine for the recreation room, and the allowing of greater flexibility in patients' bedtime and hospital attire.

Surgery under general anesthesia, which for adolescents represents a maximum degree of helplessness, is a topic that interests almost all patients, whether or not they have had, or are scheduled for, an opera-

tion. Those who have already undergone surgery tend to relate their experiences with preoperative medication, anesthesia, and the recovery room in great detail, often emphasizing the frightening aspects. Nevertheless, the staff has observed that patients awaiting surgery usually find reassurance in speaking with those who have already undergone similar surgery.

Often patients make comments not based on fact in an effort to reassure themselves or others. The staff intervenes in the rare cases where gross distortions are not modified in the ensuing discussions. However, the staff avoids interpretations that would be difficult for patients to assimilate. The subject of death falls in this category.

In our society the subject of death is taboo, and this is especially true among the sick. Although a death sometimes occurs on the adolescent ward, and at least some of the patients know when it has happened, death is seldom brought up directly by a patient. Instead, feelings and fears about death are expressed through questions about what happens when a patient gets very sick or through vague references to patients who have died. The option to deny a fellow patient's death seems to be removed once the fact has been announced and discussed in the presence of others, so the subject is avoided. If a patient or staff member does mention death directly, the group usually quickly changes the subject. When a patient obviously wants to talk either about a death on the ward or about his own possible death, but is inhibited by the group's denial, a staff member makes a point of offering him an opportunity for a private conversation at another time.

Staff meetings

One afternoon a week the psychiatrist holds a meeting for the entire staff of the adolescent services, including the medical director, pediatric house officers, child psychiatry trainee, nurses, social worker, chaplain, medical students, schoolteacher, and volunteers. Between 15 and 20 participants attend. The usual pattern is to begin the discussion with a presentation by a house physician or a nurse of a patient's history or a problem in the unit. While the pattern has remained the same, over the years a gradual broadening of focus has occurred. At first the house physicians and the nurses tended to present only "pure" psychological cases, such as suicidal or psychotic patients. Next came the inclusion of cases involving anorexia nervosa, psychosomatic illnesses,

and psychological reactions to physical disease and medical procedures, and unit problems such as the staff's reaction to a very ill, maimed, or dying child. More recently the presentations have been concerned with psychosocial problems such as drug abuse, chronic running away, pregnancy out of wedlock, or marked antisocial behavior.

The participants in the staff meetings have obviously felt increasingly comfortable in presenting their views. The resultant pooling of observations has proven to be remarkably useful in identifying behavior characteristics that might otherwise have gone unnoticed, and so in planning appropriate treatment.

One example of such cooperation is provided by the case of a 14-year-old girl who was hospitalized following a suicide attempt. On admission she was severely depressed and seemed to be having delusions. Through information shared in the ward meetings by the social worker, chaplain, and child psychiatrist, it became clear that the girl's delusions were based more on her family's fanatical religious demands than on psychopathology.

The staff meetings also make possible a systematized, consistent approach to managing a difficult patient on the ward and planning his aftercare. They have noticeably strengthened the staff morale and team sense and have produced a growing staff awareness of the psychological aspects of the patients' illnesses. This result has shown up in a steady increase in the number of staff requests for psychiatric consultations.

Nurses' meetings

Nurses are the most permanent staff members on the wards of teaching hospitals. Furthermore, they spend much more time with the patients than do the physicians. Nevertheless, medical schools customarily view nurses mainly as service providing employees of the hospital and do not include them in their teaching program. Many nurses resent this view as they watch with frustration the constant rotation and promotion of medical students, house officers, and members of the medical school faculty.

The opening of a new ward devoted to a new branch of medicine provided an opportunity to find ways of including the nurses in all the ward activities and decisions. Consequently, the ward nurses and nursing students have not only been included in the overall staff meetings but also have been provided a weekly meeting of their own with the child psychiatrist, the

fellow in child psychiatry, and the social worker.

As the only professional staff members who are permanently on the ward, the nurses play a paramount role in perpetuating the philosophy behind the unit and maintaining staff morale through their attitudes and performance. A cohesive force, they have become the vanguard in changing ward policy. For example, nurses have worked for more than a year to get the noon meals of ambulatory patients served in the large recreation room. This would aid patient socialization and, if nurses could also attend, help stimulate informal communication between the two groups. Resistance to the innovation came from the hospital food service department, which found the irregular, and from a hospital policy that forbids nurses to eat "patient" food rather than "cafeteria" food. Happily, the resistance seems to have broken down, and nurses and patients hope they will soon be able to eat their meals together.

In their meetings the nurses often speak of the poignancy of death in adolescence. The subject inevitably comes up after the death of a young person who has been in the hospital long enough for them to have developed feelings of attachment for him. Recent for example, a courageous 15-year-old boy, much admired by the nursing staff, died of leukemia the day before the weekly nurses' meeting. The nurses used the entire meeting time expressing their thoughts about his death, other patients' deaths, and death in general. They revealed deep feelings of grief, guilt, helplessness, and anger. Many of the participants later expressed gratitude for having had an opportunity to relieve their feelings in this way.

Hunter periodical

One of the primary goals of holding patient meetings is to reduce the patients' feelings of helplessness and enforced passivity. Another method the staff uses to achieve this goal is encouraging the patients to contribute to a ward "magazine," a mimeographed periodical called *Hunter Highlights* that is distributed to everyone associated with the ward. This activity provides the patients with another opportunity for self-expression and guarantees them an audience. As might be expected, most of the 250 contributions from patients thus far—all made on a voluntary basis—comment on some aspect of hospital life.

More than half these contributions reflect the kind of ambivalence in which both positive and negative feelings are combined, often, indeed, quite

contradictorily. For example: "It's very lonely here . . . I sure will be glad to go home. I can imagine it sounds like I don't like being here in the hospital. The doctors and nurses are so nice I do like being here, but I still want to go home." Or again, "I like Hunter 4. I enjoyed my visit here very much . . . I can't stand the doctor who took the beautiful blood from my vein. I hate the food very much. It stinks."

About one-third of the contributions are wholly complimentary. By contrast, only 13 are completely negative.

The subject of most criticism in these contributions—as in the patients' meetings—is food. Next to food the aspect of hospital life to come under fire most often is the ubiquitous "needle." For example:

Hi, deedle, deedle, the Doc and the needle,
The patient jumped out of his bed.
The nurses all laughed to see such fear
But the poor patient just turned red.

A 13-year-old with newly discovered diabetes expressed his feelings about injections along with recognition of their importance in this way:

In the hospital there's just one thing that everyone minds
That is loads of shots in their behinds.
One, two, three, away we go
Just three more shots. Oh no! Oh no!
No more shots for me, you see
My backside's as red as it can be.
Oh well! Since his backside is so red
We'll have to let him just drop dead.

While compliments to the staff outstrip complaints at a ratio of 6 to 1, some patients seize the opportunity for an imaginary revenge against the staff's aggressiveness. Wrote a 13-year-old girl:

Sing-a-song of doctors,
All on Hunter 4
4 and 20 interns
Kicked out the door.
When the door was open,
They all turned black and blue,
Now wasn't that an awful thing
For all the kids to do?

Adolescents who write in verse seem to be among the more sensitive and revealing. Many of the poetic entries indicate their concern about the outcome of their hospitalization, their longing for home, and, though thinly disguised, their fear of death. For ex-



A young patient in the adolescent ward of Yale-New Haven Hospital shows a fellow-patient how to score in bumper pool.

ample: "The nurses are nice/ They come if you call,/ But I won't mind/ Going home at all," or again, "As long as (the nurses) call me 'honey' and 'sweetie-pie'/ I do not think that I will ever die."

Thus, *Hunter Highlights*, in providing a channel for the airing of feelings, may help some patients preserve in some measure the sense of autonomy so important to them.

Reactions to the ward

Two years after Hunter 4 opened, in an effort to determine reactions of patients and their parents to the adolescent unit the authors of this article conducted 200 semistructured interviews, 100 of them with randomly selected patients and 100 with their parents.³ We found that the ward was well liked. Ninety-five percent of the parents voiced outright approval, many of them using such adjectives as "marvelous," "terrific," and "perfect." Of the remaining five parents, two claimed indifference and three others expressed concern about the presence of boys and girls on the same floor. "They get funny ideas if they're together," objected one of the fathers.

The unit's patients at this time ranged in age from 10 through 17. Eighty percent approved of the ward. None of the dissenters were more than 13 years old.

We found that the patients in preadolescence, especially the boys, tended to wish for exclusion of patients of the opposite sex. We also discovered that the age of 13 separated children who could accurately grasp the meaning of their diagnosis from those unable to do so. A third age-related difference appeared in the choice of visitors. While approximately two-thirds of the patients preferred parents over peers as visitors, those who chose peers were almost all 13 years of age or older, with girls outnumbering boys three to one. Since homogeneity of interest was a prime motive for creating an independent adolescent service, the unit now accepts patients under 13 only when space is not available for them on the other pediatric floors.

We also found differences in the parents' and patients' concern about the hospitalization. Generally the parents were more pessimistic about their child's condition than the patient himself. For example, no child admitted a fear of death and only eight mentioned fear of chronic disability, while 55 percent of the parents worried that their child might die or be chronically disabled. However, parents tended to underestimate their children's anxiety. Forty-six percent of parents said nothing worried their children, but only 35 percent of patients maintained they had no worries. In general, parental anxieties involved a longer view of the outcome of the illness, while the patients were concerned about more immediate medical procedures and other daily discomforts.

Some problems

The fact that the age of the patients is near the age of the staff enhances empathy between them. Empathy is very useful to a point, but closeness in age can also lead to problems. Nurses and physicians sometimes identify too closely with a patient. This hampers objectivity. For example, a staff member sometimes finds it difficult to perform painful procedures or uncritically sides with the patient against the parents in cases of family turmoil. Medical students and volunteers occasionally develop strong romantic feelings for patients, which interfere with their professional duties. Close supervision of volun-

teers and medical students is very important on an adolescent ward.

The boisterousness of adolescents as they get well is hard for some staff members to accept in a hospital setting. It is essential to have the space, the equipment, and the personnel to cope with this exuberance. The ward must also have available the controls necessary to halt unruliness, which more often comes from disorderly visitors than from the patients themselves.

In conclusion

Hunter 4 is only one of many beginnings in the subspecialty of adolescent medicine. The professional persons involved are learning a great deal about teenage patients. However, perhaps no adult can understand them as feelingly as 13-year-old Marian Dustin who wrote the following Peanuts-type vignette for *Hunter Highlights*:

HAPPINESS ON HUNTER 4

Happiness is when your doctor changes your pain medicine from a shot to a pill.

Happiness is being able to get up and go to the bathroom.

Happiness is being able to fit lots of stuffed animals on your bed.

Happiness is being able to go in and push buttons on the jukebox.

Happiness is having someone to crank your bed up.

Happiness is knowing all of the nurses' names and voices.

Happiness is giving nurses candy and hearing them say, "Oh no, I couldn't. I'll get fat. I'm on a diet" and then give in and blow their diet.

Happiness is the fun doctors and cheerful nurses on Hunter 4.

Happiness is happiness.

¹ Gallagher, J. R.: A clinic for adolescents. *Children*, September-October 1954.

² Schowalter, J. E.; Lord, R. D.: Utilization of patient meetings on an adolescent ward. *Psychiatry in Medicine*, July 1970.

³ ———: Admission to an adolescent ward. *Pediatrics*, December 1969.

LESSONS LEARNED FROM A BABY CARE CLUB FOR UNMARRIED MOTHERS

MARCH BRACKEN

In the summer of 1970 as a social worker in the Maternal and Newborn Department of the Yale-New Haven Hospital, I conducted a Baby Care Club for unmarried teenage mothers who had delivered in the hospital and had chosen to keep their babies. Six girls were involved. The club met with both failure and success, and so provided lessons for future efforts of this type. For example, we learned that difficulties in transportation may be insurmountable when the membership is drawn from all over the city, even though the meeting place is centrally located, as is our hospital. We also learned that a person with pediatric knowledge—whether a physician or a nurse—must be regularly involved along with the social worker, rather than just occasionally by invitation, if the members are to get the kind of help they need.

Nevertheless, I believe that the mothers did learn better baby care through their participation in the program, and that with correction of these shortcomings they might have learned more. I also believe that they may have learned more than was immediately apparent either to me or to the mothers themselves.

The idea for the 1970 Baby Care Club grew out of the hospital's sponsorship of a Young Mothers Program, begun in 1965 to bring a coordinated communitywide program of obstetrical, social, and educational services for pregnant teenage girls.¹

Although this program provided comprehensive services for teenage girls prior to their deliveries, there was little service available to them after the

birth of the child. Therefore, the social service staff of the Maternal and Newborn Department began to question whether its concern for an unmarried teenager should stop with the birth of a healthy child. We were aware of Bowlby's observation that a large number of babies born out of wedlock "grow up suffering from some degree of maternal deprivation and into characters likely to produce more of their kind."²

All of the unmarried mothers in the Young Mothers Program were from low-income areas, most of them were black, many were from broken homes, and most were socially and culturally isolated from the mainstream of American life. The isolation we had become aware of in these girls was not just a facet of separatism between the races. It extended to family, school, peers, and all other relationships. For example, few of the girls had confidants or best friends. They had not learned to trust, an ability that Erikson regards as basic to communication.³ Coexistent with this isolation, many of the girls seemed to have a sense of worthlessness—a pervasive depression that seemed to reflect itself in fatigue, lack of motivation, and lack of future orientation.

In deciding to sponsor a Baby Care Club, we kept in mind that the mothers we hoped to reach were teenagers still in the throes of struggle to achieve a mature identity. As such, we felt they could profit from a time to come together and share their hopes, their doubts, and their difficulties. Experience has shown that a group discussion can provide a creative and secure learning situation for adolescents, who are

often easily threatened by the intensity of a one-to-one encounter. Because teenagers are empathetic to the sensitivities of their friends and can "tune in" to help each other, we believed that healthy peer group relations could emerge through the girls' interactions in listening, understanding, and offering suggestions.

Through the Baby Care Club we sought to help the mothers fulfill the demands imposed upon them by the role of motherhood while at the same time meeting some of their own needs; help them realize how important they were to their infants, thus improving their self-image; and intervene in the repetitive cycle of deprivation by encouraging them to become aware of their infants' emotional as well as physical needs. Another of our goals was to help the girls learn about motherhood from professional workers who spoke at the club meetings, from each other, and from their own babies. We believed that an informal clublike atmosphere would attract the girls to the meetings and encourage their active participation.

The club members

From a list of girls 15 to 17 years of age who had delivered babies at the Yale-New Haven Hospital in the spring of 1970, we selected 17 who, we thought, would benefit from participating in a Baby Care Club. Our evaluation of these girls was based on their medical records and the regularity of their visits to the clinic, their care and handling of their babies while in the hospital, and their attendance and interest in school.

These girls had shown varying degrees of interest in preparing themselves for motherhood. Several had good records of attendance at the prenatal clinic and at the special school for pregnant teenage girls, and in general had assumed care and responsibility for themselves and their babies by making careful plans for the future. Others had been extremely difficult to motivate; three had dropped out of school and had later had another baby out of wedlock. Most, however, were somewhere between these two extremes. They continued to attend school and had average academic success, but unlike the highly motivated girls, they had no plans beyond a vague wish to graduate from high school. While most of these girls had relatively stable relationships with the fathers of their child, they had no plans for marriage and did little thinking beyond today.

All the girls received a handwritten letter, mailed in a pastel-colored envelope, inviting them to join the

Baby Care Club and telling them about it. The letter explained that a diploma would be awarded to every girl who attended the group meetings regularly. I followed up each letter with a home visit during which I introduced myself to the girl, explained the purpose of the club, and personally invited her to come. My answer to the question, "Can I bring my baby?," was "Yes."

Six girls accepted the invitation to join the Baby Care Club. All were black and all were still attending school. Of the other girls, three had moved without leaving a forwarding address, three could not attend the meetings because they were either working or attending an out-of-town school, and five turned down the invitation because of lack of interest.

Transportation was a major problem from the beginning to the end of the Baby Care Club. The group meetings were scheduled at the hospital. As the girls lived in a wide circle around the center of New Haven, the hospital provided a central meeting location. Public bus transportation was available, but some of the girls had to change buses twice. The meeting time, 5 p.m. Monday, was set in accordance with the wishes of the girls, and with the availability of the professional persons we had invited to speak.

For the first meeting I offered to use my car to pick up the girls who had transportation problems. We hoped that in subsequent sessions the girls would be able to come to the meetings without help, but this did not occur. However responsive they might have been during a group session, and however much they obviously enjoyed it, most of the girls lacked the initiative to arrive of their own accord.

Our attempts to involve community resources in furnishing transportation for the girls to the club meetings were unsuccessful. Neither the Red Cross nor the hospital could provide volunteers to drive the girls to the weekly group sessions. We contacted women's clubs—including the Junior League, Women in Community Services, Inc., Women's Relief Corps, and the Orangewood Women's Club—but not one was able to provide either vehicles or drivers. We then tried to attract Yale University students interested in community work by posting a job description in the student volunteer office, but this, too, was no avail. It came as a shock to us that such a community-minded city as New Haven could not provide transportation to meet the needs of a service for teenage mothers and their children.

For most club meetings, therefore, I carried the girls and their babies to and from the meetings.

my own car. Transporting the girls was a necessary reaching out technique; at the one session when I failed to pick up the members, only one girl showed up. If the club had continued for a longer period, the girls might have become committed enough to come by bus in spite of its inconvenience.

The borderline involvement, characteristic of this particular group, meant that I had to reinforce the girls' interest by continually reaching out to them. My techniques included weekly reminders of the next meeting, handwritten on pastel paper in red ink, and supplying refreshments, as well as taking the mothers and their babies to the meetings. At the later meetings some of the members brought cookies themselves—a sign of growing interest.

The meetings

The first task of the club was to help young, slightly depressed mothers increase their perceptiveness in relating to their babies. If depression had indeed catapulted these teenagers into premature motherhood, we intended to use that motherhood as a means of relieving some of their depression.

Because of the limited concentration span of many adolescents, the Baby Care Club was designed as a short-term group with six 1-hour sessions. Each meeting was focused on a specific topic representing a different aspect of mother-child interaction, and ample time was allotted for group discussion.

Although the schedule was not rigidly adhered to, it provided the girls with a jumpingoff place at each session for discussing subjects that concerned them. Often the initial question was "What are we going to talk about after today?" We found that the girls appeared to feel less vulnerable when there was an announced subject. This is in agreement with Arthur Pierson's views of group social work with the poor: "It might be useful at times to give the group a social emphasis so that members could have something concrete to relate to."⁴

During the group meetings we wanted to acquaint the young mothers with the skills and services of workers in the various professions concerned with child care. Therefore, we invited specialists to participate in specific meetings, among them two pediatricians, a child psychologist, the director of a day care center, and a nurse. The girls frequently asked the visitor who was coming to the next meeting and often asked the visitor what his specialty was. Each new speaker produced excitement among the members; at times they seemed to develop a "special" feeling

of pride because of the array of guests interested in attending their meetings.

Before the first club meeting, I drew up a list of topics that I thought would interest and benefit the young mothers. The schedule for the six meetings was as follows: (1) Caring for Your Baby; (2) How Do Babies Learn?; (3) What Toys Does Your Baby Need?; (4) How Does a Working Mother Care for Her Child?; (5) What Clothing Does Your Baby Need?; and (6) Toilet Training Your Baby. I found the schedule basically workable, but I would make a few changes if I were conducting another club.

At the meetings I encouraged the girls to request topics and speakers. While they did not tell me who they wanted, as the sessions progressed they became increasingly adroit in suggesting topics they wanted. We modified the meetings to include their suggestions.

The topic "Caring for Your Baby" was an appropriate beginning. Most of the mothers were not informed about the basic needs of their babies, and so followed child-rearing superstitions and remedies handed down from their parents and grandparents. One mother with a 4-month-old baby had learned a great deal through experience, but even she had little awareness of the reciprocal emotions involved in mother-child interaction. Guest speaker for this meeting was the pediatrician-director of the hospital's Newborn Special Care Unit. He presented basic information on infant care, touching on such issues as feeding, sleeping, clothing, and how to recognize when a baby is sick. As the young mothers asked questions about the physical needs of their babies, they appeared to feel and relate to a common bond of motherhood.

Perhaps the meeting on learning came too early in the series. When I showed a lengthy film "How Babies Learn" that emphasized the importance of mother-child interaction and highlighted developmental milestones, the club members became restive

March Bracken joined the social work staff of Yale-New Haven Hospital's Department of Maternal and Newborn in 1970, where she directed the program described here. After graduating from Boston University School of Social Work in 1969, Mrs. Bracken worked at the Children's Center in Hamden, Conn. Previously she taught school in Vienna, Austria, while studying clinical psychology at the University of Vienna.



and bored. They seemed more eager to relate to their own babies and to each other than to a visual aid. In subsequent meetings, however, the girls discussed the film. I believe this film would stimulate more interest if it were to be divided into two parts for showing at the fourth and fifth meetings. A pediatrician from the Yale Child Study Center whose specialty was emotional development was guest for the meeting on learning, as well as the final meeting on toilet training.

The demonstration of toys at the third meeting stimulated the enthusiasm of the mothers. A child psychologist showed how to use toys to foster mother-child interaction, and the mothers were obviously delighted when they saw how their babies responded. One of the mothers, relating the experience to her own deprived childhood, said at the end of the meeting, "The only trouble is I didn't get to play with the toys enough."

At the fourth meeting, the director of a day care center explained how a working mother can arrange care for her child. The director focused the discussion on day care centers: their availability, cost, and attitudes of staff members toward child-rearing and parental involvement. Although this was an informative meeting, there was no discussion of other concerns of the working mother, such as the choice of a babysitter, difficulties that arise when a mother takes over care of the baby, and the problems of pursuing a career while having a baby to rear. It would probably have been more helpful to highlight day care as one concern of the working mother, rather than to devote an entire session to it.

At the fifth meeting, although the scheduled topic was "What Clothing Does Your Baby Need?", the mothers discussed clothing, furniture, play materials, bathing equipment, and strollers. When the girls realized the guest speaker was a nurse from the hospital's Maternal and Newborn Department, they began to ask her questions about contraception. All the teenage mothers had received information about birth control in the hospital after delivery, but it became evident at this meeting that many of their questions had not been answered. In any future group of this type, I would schedule an entire meeting on family planning early in the series, perhaps at the second meeting.

The topic of toilet training may appear somewhat inappropriate for mothers whose babies are only a few months old. We deliberately included this topic at the final meeting, however, because we knew that

mothers who were themselves emotionally deprived in childhood have great difficulty in understanding and dealing with the developmental needs of the 1½ to 2½-year-old child. Many young mothers become baffled and confused as the passive, helpless infant so cute and doll-like in his new outfit begins to develop a distinct personality with a will and energy of his own. The guest speaker, a pediatrician, explained that the mother's role must change in response to her child at this time and that she herself often relives conflicts with her own mother around the issue of toilet training. Then some of the mothers described their views of discipline. One mother remarked, "A baby should be potty-trained as soon as he can sit, and if he doesn't do something, you don't let him eat." In the discussion that followed, we suggested less severe alternatives for dealing with a young child.

Some thoughts

On what basis does one evaluate such a group? Is the amount of time spent in preparation and reaching out to young mothers justified? Since I have found it more difficult to motivate young mothers postpartum than prenatally when their anxieties about labor and delivery are keen, I suggest that a social worker who wants expressed gratification and measurable success does not begin with groups on infant care.

The effects of the club on peer relationships are more easily observed than any measure of what the mothers may have learned. As already mentioned, these young mothers were emotionally isolated and did not have close friends. Yet by the end of the Baby Care Club meetings, they were sharing with each other the joys and difficulties of motherhood. As the girls responded to each other, they began to help each other. One club member told the group that her mother was mentally ill—although she had never mentioned this to the social worker—and discussed with the members her fears that her baby would be retarded. Several weeks after the final meeting of the Baby Care Club, one member invited another to her home for a weekend visit. Another young mother asked the social worker to talk with a club member who was planning to drop out of school. After the group had closed, one young mother volunteered to speak about her own experience to some prenatal groups at the hospital because she missed the club meetings and wanted to help the girls who had not yet delivered their babies.

However, the difficulty I had in involving young mothers in the club at the time was a source of frustration and pain. As the social worker, I became the only constant group figure for the club members, and I had to act as a bridge between the girls and the invited guest. This was a difficult role to play because the visitors were not familiar with either the individual or the group stage of development. Therefore, I met with each guest before the meeting to prepare him for the problems of reaching the young mothers.

Social workers often have to modify their roles to meet the needs of their clients. In this case, I had to come up on the physical and emotional development of infants and on available community resources. With the girls I learned a great deal from the variety of professional persons who spoke to us and so became better prepared to lead this kind of group by myself.

I now believe that the cohesion and group solidarity of the club members might have been strengthened if a second professional worker with knowledge of the physical development of infants had attended the meetings regularly. Such a plan would not, of course, have exposed the girls to knowledge of the variety of services covered in our series, but it could have increased their sense of trust in the group leaders.

Preferably, the coworker would be a pediatrician. Getting to know one pediatrician well at club meetings might encourage the young mothers—who need to learn that a doctor can be questioned—to relate to a medical authority in a more assertive way. Once they had developed the ability to interact with a physician, they could apply it to future relationships. Furthermore, a pediatrician could provide medical care for the babies.

For one person, the attempt to reach, to involve, to teach, and to motivate deprived young mothers is often a frustrating and lonely undertaking. With a coworker to share the failures and the successes, however, a leader of a young mothers' group can develop a more balanced perspective and both can benefit from

an invigorating review of the meetings. This is currently the practice in our prenatal groups.

While I believe the Baby Care Club provided a needed service by giving teenage mothers an opportunity to talk to each other and to learn about infant care and development, I think it would have been more helpful to the mothers if the program had been a joint undertaking of an interdisciplinary team including a social worker, a pediatrician, or a pediatric nurse-practitioner.

What agency should provide such a service? We often questioned the efficacy of a meeting at the hospital. One problem of attendance was that the club members considered the hospital a white establishment institution that was not flexible enough to reach out to them and meet the needs of their community. I believe that the club would have been more effective if it had met in the well-baby clinics that are provided by the Visiting Nurses' Association within the mothers' home communities. Attendance would not be the problem it was in our club, for many girls take their babies to these clinics for periodic checkups. Such clinics are natural settings for teaching mothers that the emotional needs of their infants are as vital as the physical needs.

Medical services for infants are offered through well-baby clinics, pediatric clinics, private practice, and group practice. Any of these pediatric sources might appropriately teach child care to groups of young mothers. Such service is actually *preventive medicine*—the optimum of health care—that benefits not only the mother as she embarks on a new role and attempts to meet its demands, but also the infant.

¹ Sarrel, Philip M.: The young unwed mother: the role of the obstetrician in a comprehensive care program. *Obstetrics and Gynecology*, December 1968.

² Bowlby, John: Maternal care and mental health. World Health Organization, Geneva, Switzerland. 1952.

³ Erikson, Erik H.: *Childhood and society*. W. W. Norton and Co., New York, N.Y. 1963.

⁴ Pierson, Arthur: Social work techniques with the poor. *Social Casework*, October 1970.

AN ENCOUNTER WITH FOSTER PARENTS



KATHRYN CLOSE

● "Society expects you to be a saint, a parent, a psychologist, and an expert in mental health, but it certainly doesn't provide you with the help you need or the deference you deserve."

The speaker was Edward F. Zigler, director of the Office of Child Development. The "you" he was addressing were the participants in the First National Conference of Foster Parents, which met in Chicago May 7-9. Open to foster parents and to social workers accompanied by foster parents, the conference was convened by the Children's Bureau, the Community Services Administration, and the Christopher Street Society, a Detroit-based foster parents' association. It drew 850 people from 47 States, the Virgin Islands, and Canada, three-fourths of whom were foster parents—people who have opened their homes to other people's children because they know these children need their help.

Speaking to them at the opening session Dr. Zigler maintained that if this Nation took care of the health needs of children and provided the kinds of services that can strengthen family life, the problems of foster care would be less severe. He pointed out that the child in foster care today has been deprived both physically and emotionally and therefore makes great demands for love and parental skills on the adults who take him into their home. Such children, he said, characteristically exhibit two paradoxical traits: An insatiable need for attention and affection, and a reluctance to interact with an adult.

Dr. Zigler listed five "not innovative but essential"

things that need doing for the benefit of these children: (1) Reimbursing their foster families for expenses incurred in providing for the child's needs and paying them salaries for their service; (2) exercising care in the selection of foster parents to screen out "those who should never have anything to do with children"; (3) training foster parents to deal with the kinds of problems damaged children present; (4) improving the relationship between the social worker and the foster parent—"when they are at odds the child is caught in the middle"; and (5) providing the social worker with good training, a decent wage, and a low enough workload to enable him to give the foster parents the help they need.

Warning against "doing cost-benefit analysis at the neglect of the quality of life," Dr. Zigler said, "I'm not concerned about whether you keep a child from the future welfare rolls, but about what kind of childhood you give him."

He was not alone in his concern for the quality of childhood. Perhaps these foster parents were not saints or experts in anything that brings an academic degree, but to this reporter much of what they revealed about themselves seemed to bear some relationship to both saintliness and expertise. With some measure of each, how else could a woman take in one deformed "dying" baby after another and nurse him to health and alertness? How could a couple with three children of their own take in two "retarded" bed-wetting, soiling, school-age children and bring them to the point where they could enter school—one in a regular class? How else could

southern woman with three children of her own like on somebody else's troubled and troublesome teenager and stick to her even after the girl became pregnant as a result of mixed-racial liaison? ("We both grew up because of this experience," she said.)

Inquiring reporters (noticeable by their absence) could have picked up hundreds of similar pieces of evidence at this conference of a kind of love "that assesteth all understanding," all told with modesty or matter-of-factness, for the foster parents did not seem to see anything unusual in what they were doing. They were not seeking deference—though they did discuss the need for a "better image"—but they *were* seeking help in doing a better job, help from each other and from whoever else would give to them. That was clearly evident in the earnestness of their participation. Not only were all the scheduled meetings—three general sessions and 24 small group discussions—attended fully from beginning to end, but the conferees themselves added 12 buzz sessions on how-to-do-it subjects for their only "free" evening, Saturday night. In the small groups they asked questions freely, described their problems (only occasionally getting off the subject onto what they themselves dubbed as "war stories"), expressed their viewpoints, and listened. Sometimes they even testified to a change of view as a result of the discussion. Always, for this age of confrontation, they were refreshingly polite.

Foster fathers were there in unusual proportions—making up about a third of the foster parents present. That these men did not consider "fostering" simply as a woman's task was not only implicit by their presence but explicit in such frequent statements as: "You can't get a foster kid in the family and expect the wife to do it all. You have to be a full-time father." "One way I've found of uncorking a teenage boy who wants to talk is to take him for a walk."

Some goals

What was also refreshing to a battleworn conference correspondent was the lack of personal jockeying for status within the group. The conferees sought status for foster parents as partners in the agencies they served. They spoke of themselves as givers, not consumers, of service and sought recognition of this difference as important in their ability to serve the foster child. Many of them had founded or joined associations of foster parents as a means of achieving this goal, and some said that one of their

chief interests in coming to the conference was to find ways of making these associations more effective in improving services.

Some participants saw the formation of a national association of foster parents as the chief objective of the convening of the conference and welcomed this possibility as providing a channel not only for instilling life into their local associations, but also for working for measures to meet the unmet needs of children—or as more than one person put it, for "working ourselves out of our jobs." The few who at first seemed to view the suggestion of a national association as a government plot to "push us around" seemed to lose their suspicion as the discussions progressed, for at the final session a resolution setting up the machinery to establish such an association passed unanimously.

Apparently anticipating this outcome, Stephen Simonds, commissioner of the Community Services Administration, speaking at the luncheon session urged foster parents to become "a new voice in behalf of children." He suggested that a new partnership be formed between foster parents and government and also, where appropriate, the foster child himself, and the natural parents. Among the goals for such a partnership he named better rates of payment for foster care, improved reimbursement procedures, professional fees, better procedures for providing medical care, changes in adoption laws to free children for adoption, and provision of services to help the child stay in his own home. Mr. Simonds urged the foster parents not to "become a protectionist group" but to become "an advocate group for children wherever they are."

The uses and misuses of local foster parents' associations occupied a large portion of the conferees' attention. At the Saturday morning general session, a panel of three foster parents who were active in local associations warned that any such association is in danger of running down unless it has more definite goals than mere socializing or even taking up grievances with agencies. Convinced that "you can't have good foster parenting unless you have foster parents talking to each other," one panelist asked pleadingly what to do to revive a once lively and now nearly moribund association. The two others suggested some answers: Work with the agency and its social workers; don't rely on the same group of leaders forever, but train others to take on responsibility; establish a positive goal and in choosing this don't "fall into the trap" of asking "what do we want?" but ask rather "what are the strengths and

weaknesses of our program?" Expressing a firm belief that "a child who is going to make it as a good parent must have the experience of living in a family," one of the panelists warned that unless foster parents set the goal of learning how to help the kind of emotionally disturbed children that need foster care today, "the whole thing will turn to group homes and institutions."

A linked circle

The interconnection between foster families, natural families, and agencies was the real theme of the conference, proclaimed in a large blue and white conference banner with the three components linked in a circle. Occasionally, the discussions revealed a few weaknesses in the linkage—hints of "cold wars" between foster parents and natural parents and between foster parents and social workers. Some strong forging, however, obviously took place at the conference. For example, a foster father, after listening to a psychiatrist's recommendation that children who can remember their parents have continuing contacts with them, announced that he "agreed in principle but disagreed in practice," explaining that every visit home made by his two foster children results in "terrible turmoil afterwards."

In the ensuing exchange of good and bad experiences among the foster parents in the group, stories unfolded of children who had come to grief because of an unsatisfied longing to see rejecting parents, and of foster parents' efforts to reach out to natural parents not only for the sake of their children but also for the sake of the natural parents, who "as human beings also need to be loved." At the end of the session the once-skeptical foster father signified his intention to work against a ruling in his agency forbidding contacts between foster parents and natural parents. "I see now it is more advantageous to contact the natural parents than not," he said.

Evidence that sweetness and light do not always prevail between social workers and foster parents appeared in some foster parents' expressions of two paradoxical types of resentment: (1) Against social workers' interference—forcing the child to make home visits, holding "secret" discussions with the child, returning the child to "parents who damaged him in the first place," trying to "take over" a foster parents' association; and (2) against social workers' failure to help the foster parents understand how to deal with an emotionally damaged child—"If I had known then what I have since learned from another

social worker, I wouldn't have had to give up the child!" "If you are social workers and are spending your time with kids, cut it out and work with the foster parents."

On the other hand, testimonials to social workers abounded: "Whenever I have a problem with my child, I take it to my social worker and she helps. 'When I let my frustrations out on the social worker they turn the other cheek, and I love them for it.'"

The foster parent who thus spoke of social workers in the plural had "fostered" many children. Perhaps she got at the crux of the problem when she said "There are good social workers and bad social workers, patient ones and impatient ones. They too are human beings."

As in larger cold wars, however, sometimes the difficulty may arise simply from a misreading or distrust of the other fellow's intentions—a point brought on by one woman's story of what happened when her foster parents' association decided to admit social workers: "Before we got together we were afraid to tell the worker 'I think you're wrong' lest he come and get the kid. But when we got together we found the workers were worrying every time the phone rang: 'I wonder whether they want me to come and move that kid!'"

Role confusion

There was some evidence too of a confusion in understanding of the foster parent's role. Some foster parents saw themselves as the responsible agent for the child: "I see the child every day. I'm the one who should decide what he can do." Others were obviously glad not to have to make crucial decisions.

Some of the difference in attitude may have stemmed from actual differences in the tasks the foster parents had assumed. These were of four kinds: (1) Emergency care; (2) the care of babies awaiting adoption or of other children needing temporary care; (3) the specialized care and treatment of extremely damaged children—mentally, physically, or both; and (4) the more or less permanent care of rejected children. True, the lines between these functions also seemed to be blurred—temporary care turning into long-term care in a kind of man-who-came-to-dinner fashion ("They asked us to take her for 3 months, but she's been with us for 3 years") and permanent care turning out to require a great degree of special skill ("He was 7 years old when we got him and he couldn't speak a word—now at 10 he has learned to count and he can tell us what he wants."

The foster parents with the proprietary feeling were often those who had had a child or children in their home over long periods and were only a technicality away from adoption. "We have two brothers, ages 5 and 9—we can't afford to adopt them both and naturally we couldn't hurt one by adopting only the other." While, like the others, they expressed need for full reimbursement for expenses, or an opportunity for adoption on a subsidized basis, unlike some of those providing specialized care, they did not want salaries for their services.

The foster parents at this conference rarely used the term "foster child." They spoke of "my child" meaning the foster child, "my own child" when they needed to make a distinction between the two, and "my children" often meaning several "own" and several foster children. And they apparently refused to make distinctions in their care: "Our own child wanted a bike for Christmas, but the agency wouldn't let one for our foster child, so naturally we had to buy two."

Numerous statements attested to this tendency to dig into the pocket to meet expenses for "extras"—and sometimes the "extras" were as necessary as school clothes or medical or dental care. The payments received for a child's maintenance, according to one foster parent after another, barely cover his food bill—especially if he is a teenager: "We get \$70 a month. Our boy could eat that up in a week." One foster mother told of taking her foster child from doctor to doctor in search of one that would accept him for treatment and await the slow reimbursement procedures of Medicaid—the chief resource for medical care for foster children. When the search proved vain she agreed to pay the medical bill herself. Others told of similar experiences.

Obviously the rewards of foster care were not viewed in terms of money. But the rewards were often mentioned. One woman described them simply: "Although I have had many broken hearts with my children, I have also had many joys."

Some observations

Each of the discussion and buzz sessions had a specific "how to" subject focused on some aspects of getting better laws and financing for foster care, improving agency foster parents' relations, educating the public about foster care, recruiting foster parents, or dealing with problems of emotionally disturbed children.

However, the reports of these groups showed that

Kathryn Close retires as editor of CHILDREN with this issue. She came to the Children's Bureau in 1954 to edit the then new interdisciplinary journal. Previously she was associate editor of *Survey* and *Survey Graphic* magazines. Miss Close plans to do free-lance work in Washington, D.C.

the discussions crossed subject lines freely, dealing not only with the assigned subject, but also with whatever the participants felt strongly about. Thus a group on getting better laws and financing discussed not only the possibility of working through a national foster parents' organization and ways of assuring medical care for foster children, but also spent some time on the unresolved question of whether foster children should or should not use their foster parents' name (some saw the use of the foster parents' name as making life easier for the children in school—others, as causing difficulties for the child in later life); a group on improving the foster parents' image talked at length about foster parents' and social workers' roles in permanent foster care; and a group assigned to discuss new ways in foster family service, such as salaries, status, and specialized fostering, also spent time decrying the present inadequacies of medical care for foster children.

What becomes apparent from a reading of these reports is the interrelatedness of all these subjects and the possibility that the solution of one problem depends on the solution of another. For example, one discussion group on a rather specialized subject—the liability of foster parents for the injury or death of their foster children—revealed the importance of opening up communication between agencies and foster parents, for some of the participants indicated that they had no idea whether or not they could be held liable in a damage suit and had rather complacently assumed that the agency would cover them should such an unfortunate event occur.

One characteristic about foster care in this country that could be detected from all these discussions is the diversity in rules, regulations, and practice among the States, counties within States, agencies within counties, and perhaps even social workers within agencies. One agency encourages visits between foster parents and natural parents; another forbids them. One agency places enough children in a family to blur, if not erase, the lines between a foster family home, a group home, and an institution; another adheres rigidly to legal limits on the number of children allowed in one foster family, even when this means

losing an opportunity to remove an unhappy child from an institution. One agency provides foster parents with continuing inservice training and supervision; another leaves them to their own devices except when an emergency occurs. One social worker sees her task as working only with the child; another operates from the assumption that the best way to help a child is by helping the persons he lives with understand why he acts the way he does and what to do about it. One agency allows a foster family to take their foster child with them if they find it necessary to move across State lines; another takes the child away even if the move is to a nearby State. ("My husband had to turn down a better-paying job last year because we couldn't turn our backs on our boy.")

The revelation of these and other differences prompted several discussion groups to urge standardization of laws and practices relating to foster care.

The outcome

At a packed general session on the final day a conference report committee—composed of 10 foster parents, one from each of the 10 HEW regions, and three social workers, from the West, Middle West, and East—presented the gist of these reports and a list of recommendations culled from them in a working session that had lasted until 4 o'clock in the morning. After considerable debate, the conferees voted unanimously to accept two recommendations, which together would result in the formation of a National Foster Parents Organization and the convening of another National Conference of Foster Parents at an unstated future date. Under these resolutions the conference report committee is directed to appoint a ways and means and objectives committee to be charged with arranging the next conference and preparing a constitution and bylaws for the new association, to be presented at that conference for a vote.

The other recommendations, all of which the conferees voted to refer for consideration to the ways and

means and objectives committee, were, in brief:

- That a national Action for Foster Children Week be sought.
- That foster parents and other agency staff work as a team.
- That an appeals board be set up to hear differences between agencies and foster parents, with rotating membership and equal representation from the two groups.
- That foster parents write to their insurance companies to find out whether their homeowner policies cover their foster children, and that they urge their agencies to provide such liability insurance for them.
- That a professional advertising campaign, developed for the Christopher Street Society, be made available to all groups desiring it.
- That investigation be made of the exact meaning of the Federal income tax law in relation to foster children.
- That a national newsletter for foster parents be established, and that its first issue be sponsored by HEW.
- That resources be made available for foster family care of children on Indian reservations.
- That a directory of foster parents associations be published.

In closing the conference, Beatrice L. Garrett, the Children's Bureau specialist on foster family services, underscored "the supremely important quality in all members of a team working to improve the lives of children: 'the true compassion for people who have been hurt, the true parental love that pushes one way beyond the call of duty.'" Without this quality in the people involved, she said, any organization established will prove to be of little value. And she clearly implied that among those present that quality existed in a high degree.

SOME OPINIONS ON

FINDING FAMILIES FOR BLACK CHILDREN

ELIZABETH HERZOG

CECELIA E. SUDIA

JANE HARWOOD

As a preliminary step in an effort to increase the availability of adoptive homes for black children, the Children's Bureau and George Washington University recently undertook an experience study—that is, a consultation with people selected because of their experience in the field of adoptions or because of their knowledge of black communities. The study was undertaken in the belief that these people could define some crucial elements that must be taken into account in planning a recruitment campaign: the incentives that might be built up; the obstacles that must be removed; and the facts or beliefs related to recruitment methods.

One hundred persons were interviewed in five large cities. They included adoptive parents, members of social agencies, and community representatives (persons in key positions in black communities). The interviewers, all black except one, were four social workers and one sociologist.

A full report of the findings is being published by the Children's Bureau.¹ Here we merely outline some of the general patterns that emerged.

Two-thirds of the respondents were optimistic about the possibility of substantially increasing the number of adoptive homes available for black children. "The homes are there . . . agencies have not reached them." Only one respondent definitely said that it would be impossible to find enough adoptive homes to meet the need.

The respondents usually suggested that a decision for or against adopting would be the result of many interacting elements, or in some instances would

really be a decision by default because little or no thought had been given to the subject.

Most respondents mentioned reasons for adopting, although the focus of the inquiry gave greater emphasis to other points. The most frequent reason was love of children. "A child is a joy."

Although many mentioned, and others probably assumed, inability to have a child of one's own as a reason for adopting, respondents by no means took for granted that only the childless should adopt.

Why people don't adopt

The respondents discussed both parent-centered and agency-centered deterrents to adoption. Among the former were—

Lack of information. Although the child-placing "experts" were, expectably, far more informed than the "community representatives," the strong consensus among respondents was that "People just don't know the magnitude of the problem and they should be told about it." A few pointed out, however, that other issues and problems have far higher priority for those who "are working on how to solve large social ills."

Parent-centered anxieties. Economic insecurity was mentioned by at least two-thirds of the respondents. Again and again they pointed out that black families have lower incomes, less job security, fewer economic reserves than white families.

You know also how much blacks fear the loss of security . . . not knowing where the next money will be coming from, is a very important fact of life.

Limited income, some pointed out, means limited space and inadequate housing, as well as insufficient funds to feed, clothe, and provide medical care for another member of the family.

Some respondents linked low and uncertain income with the readiness of needy black families to care for the children of equally needy relatives. Such families, they suggested, are hardly able to undertake more.

There are more unofficial adoptions in the black communities than official adoptions through agencies.

More than a third of the respondents said that sometimes a black man objects to adoption as "an affront to the male ego;" that "he feels it takes away from his manhood." A few suggested that this attitude is less frequent among younger and better educated men than among older and less educated men, and one said it may relate as much to class as to color—since extreme pride in virility has been found in studies of other impoverished groups. A few others, however, emphatically denied that black men "have a certain thing about adoption."

Anxieties about the child. Well over a third of the respondents mentioned anxiety about the child as a possible deterrent. For the most part this centers on the idea of "bad blood." Would the child of parents either unable or unwilling to rear the child themselves inherit undesirable traits?

The respondents who regarded such fears as deterrents tended not to view them as valid reasons against adoption. Several said that the "bad blood myth" is becoming less potent as people are better educated.

A very different anxiety about the child, mentioned occasionally, is a fear of losing him, psychologically or physically, after learning to love him: anxiety about having to tell the child he is adopted, or fear that the natural parent might want to reclaim him later. "You get very attached to a child and it would be awful to have that kid taken away." Such fears were, for the most part, viewed as groundless or exaggerated by the respondents.

Agency-centered deterrents

The deterrents to adoption mentioned most often and most vehemently concerned the policies and practices of child-placing agencies. Overall, the criticisms suggest that some popular misconceptions

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operate as strong deterrents to adoption; and some deterring practices already discarded by many agencies still survive among others. Some of the sharpest criticisms came from staff members of social agencies; while some of the most appreciative comments about agencies came from adoptive parents.

The agency's image. Half the respondents said that the public image of "the" social agency tends to discourage people from applying to adopt a child. The social agency, they said, is widely perceived as forbidding, threatening, as "screening out rather than screening in," as demanding perfection in adoptive parents, as sitting in judgment with power to give or to withhold.

Within this general image the respondents mentioned three major criticisms of agencies: (1) Middle-class bias; (2) white orientation; (3) readiness to reject.

One-third said child-placing agencies were perceived as seeking only well-educated applicants, with stable, above-average incomes, spacious homes, and middle-class manners and habits.

Agencies were criticized almost as frequently as "racist"—less by deliberate intent than by unrecognized built-in biases: "They haven't really tried to understand the black community."

However, some respondents told of efforts by specific agencies to eliminate "white bias" and to modify the agency's image in the black community, although they thought not enough of this is being done.

Some suggestions were offered to counteract such "institutional racism". A few recommended whole black staffs and boards, since white social workers are "not used to black people."

I think there has to be some exploration of all-black agencies. We have to be in a position to set up our own definitions and criteria. Often this amounts to a totally different definition of family and environment.

Comments concerning race and class bias came often from white respondents as black, and more often from agency representatives than from adoptive parents or community representatives.

Social workers' attitudes. Closely related to the "image" of the social agency was the image painted of the social worker.

The most frequent criticisms involved general attitudes of social workers, such as "negative" or "judgmental", and again race and class bias. A number of comments, however, were neither critical nor favorable, but rather stressed the qualities necessary for carrying out the social worker's role—the need for warmth, understanding, familiarity with community resources, and ability to conduct "interviews that are not interrogations," to "listen and really hear what people are saying," to "assess behavior beyond superficial level," to put applicants at ease, and to help them decide what kind of child they want."

Respondents who imputed racial bias or communication problems to the social workers sometimes suggested that those who deal with black adoptive applicants should themselves be black.

Because of lack of knowledge of language patterns and styles in the black community, I think that whites often completely misinterpret feelings that blacks express.

At least as many, however, saw the race of the social worker as far less important than skill, human understanding, and ability to communicate well with different kinds of people.

Class bias was mentioned somewhat less often than racism," and occasionally was imputed to black as well as white social workers. Social workers, it was said, "fail to recognize the strengths in poor families."

Several respondents suggested that agencies provide inservice training to help staff members overcome problems of attitude and communication.

Specific agency deterrents. The length of time and the "redtape" involved in completing the adoption process were frequently mentioned as deterrents. Many respondents suggested that the process could be streamlined, but said that even now the redtape is probably not as excessive as is generally believed.

The redtape people expect really turns them off. You hear hearsay, such as there's a lot of redtape; you have to be the parents of the year in order to get a child . . . (but) I went through less for this adoption than for a lot of other things.

Feelings were mixed, however, about efforts some adoption agencies are making to reduce the waiting period for black applicants, some interpreting this as evidence of a double standard for whites and blacks.

The agency seemed not to be able to stick to a standard here a black child was involved. I know it is hard to place black children, but should just any home be accepted?

Agencies' criteria for adoptive parenthood were regarded as deterrents by a substantial minority of the respondents. They recommended less emphasis on externals, such as income and housing. What matters most, they said or implied, is that adoptive parents should love children and be able to give them firm guidance.

. . . the agency makes you feel like you got to move up and dress fine rather than just being able to love and to help a child be well adjusted and allow the child to grow.

Many respondents suggested helping potential adoptive parents with financial supplements, if necessary. On the whole, however, those who mentioned "external" requirements leaned to the opinion that adoptive parents should be able to support their families without assistance. Several respondents gave evidence that agency requirements on income are less stringent than supposed.

A requirement that an adoptive mother should stop working was viewed as a serious deterrent for many black families in the few places that still have such a rule.

Among specific deterrents mentioned as existing in many, though not all, agencies were inconvenient location and hours, rigidity in rules and practices, agency fees, and lawyers' fees.

The adoption study. The intensiveness of the study that precedes acceptance of an applicant was reported as a deterrent by over half of the respondents. Adoptive parents tended to be less critical than agency respondents but more critical than community representatives. The criticism centered on "nosey" and "humiliating" psychological probing, regarded as excessive and incompatible with the life style of many potential adoptive parents.

. . . asking a person how they feel about something is very middle class. Many people aren't used to discussing their feelings.

While a few defended the necessity to "screen applicants carefully so 'undesirables' will not be accepted," most respondents stressed a need to reduce psychological study to the essential minimum.

Efforts to match the characteristics of a child to those of the adoptive parents were referred to by less than a third of the respondents—sometimes as deterrents, sometimes as incentives to adoption. No consensus emerged about whether agencies should or should not try to match, nor about how much or how effectively they try, but there was evidence that both agencies and applicants are now less insistent about

matching than they once were. A few said growing recognition that "black is beautiful" has reduced black applicants' desire for a light child.

Inquiry into the existence and basis of infertility in the adoptive applicants was decried as arousing anxiety and distaste in prospective adoptive applicants, especially men. A sure way to lose an applicant, it was said, is to inquire about causes of childlessness during the initial telephone conversation.

From the initial application to completion, adopting a child was usually seen as a tense and anxious process. About one-fourth of the respondents said the agency could allay the anxiety by explaining the procedures to be followed and the reasons for them, providing feedback where appropriate, and maintaining contact with the applicants.

Enlarging the target group

Again and again the respondents stressed the need for agencies to reach for adoptive parents beyond the traditional target group—white middle or upper income childless couples between the ages of 25 and 40. They were asked about a number of possibilities: single or widowed persons; couples with a different racial background than the child's; older couples; couples whose income must be subsidized to make adoption possible; and the child's foster parents.

A recurrent comment was that the special type of placement under consideration, whatever its disadvantages, is better than letting the child grow up in unstable foster care or in an institution.

One-parent adoptions. More than two-thirds of the respondents expressed outright approval of single-parent adoptions, and very few expressed outright disapproval. "One parent is better than none," they often said.

Approval was repeatedly linked, however, with stipulations that the age and sex of the child must be appropriate—usually defined as past infancy and of the same sex as the adopting parent—and that the motivation and personal makeup of the applicants must be carefully studied.

For the most part, a single parent adoption was viewed as adoption by a woman. The most frequent qualifications of approval related to the need for the adoptive mother to be mature, responsible, emotionally stable, economically adequate, and able to provide male models and companions for the child. The relatively few who expressed misgivings about such adoptions warned against the possible motiva-

tions of one-parent applicants—they may be impelled by their own need rather than by interest in and ability to care for a child.

Some respondents approved such adoptions as second choice, acceptable only if a two-parent home is unavailable, but others saw them as "a desirable alternative."

Only a few respondents included unattached men in their consideration of single-parent homes but among those, approval—usually qualified—was far more frequent than disapproval. The chief objection was that a man would find it more difficult than a woman to be both mother and father to a child.

Cross-racial adoptions. No subject evoked stronger expressions of feeling among the respondents than "transracial" adoptions. Approval was somewhat more frequent than either disapproval or no definite judgment, but disapproval was expressed with more intensity.

Those who spoke from direct experience or observation came out two to one in favor of cross-racial adoptions. Those who based their views on hearsay or on principle—chiefly the community representatives—were a little more often opposed than in favor. Black respondents divided evenly for and against such placements, while whites were a little more often in favor than opposed.

The main reasons for favoring transracial adoptions were belief that there are not enough black adoptive homes available to meet the need, that such adoptions are better than none for children in need of families, and that white couples who want to adopt black children are likely to have good potential for parenthood.

Most people thinking about adopting transracially knew they'll have problems, but they have the strength to come to grips with them.

Leading all reasons for opposition was the problem of identity, mentioned by about one-third of all the respondents, including some who gave mixed or qualified opinions.

White families could never provide a black experience for a black child. They could never adequately help a child with his black identity and pride in his heritage.

Even if the immediate family experienced no problems, it was argued, the child might suffer from negative attitudes of relatives, neighbors, schoolchildren, teachers, and the general community. "He will never feel really accepted."

A scornful fraction of the respondents raised ques-

ions about the "real" motivation of white parents who adopt a black child. Such adoptive parents, they suggested, are impelled either by social guilt or by an image of themselves as model liberals.

When you talk with them, they say everything is happy, or fine and lovely, but they don't know what the child is thinking and they don't know what kind of problems he has because they are so busy taking care of their own needs.

Two respondents mentioned that two black social workers' organizations have taken a stand against cross-racial adoptions.

Strong opposition was occasionally coupled with the charge that, instead of really trying to find black adoptive homes, the agencies are "going all-out to find white homes for them."

Transracial adoption should be the last and final resort. No matter how hard they might seem to have tried, no agency has made a concerted effort to reach black people who could adopt all these available children.

Respondents with uncertain views said that a transracial adoption should be considered only if no other alternative exists except an institution; that it is still too early to know how black children will fare after 10 years as part of a white family; and that because the outcome will depend on the individuals involved, such adoptions must rest on careful pre-placement evaluation not only of the adoptive applicants, but also of their neighborhood, the climate of their community, and the attitudes of their relatives.

Subsidized adoptions. Nearly three-fourths of the respondents expressed some opinion about subsidized adoptions, their views running 10 to one in favor, very few against, and a few mixed.

The chief reasons given for approval were that subsidy would make the homes available for many people who would make good parents but cannot afford to adopt—foster parents who have grown attached to the children in their care, young couples who would need only short-term subsidies until their incomes become adequate to provide for a child's needs, and perhaps even public assistance recipients.

However, a few agency people reported that in some places where adoption subsidy is legally authorized, "agency staffs aren't accepting the idea." "People just aren't being referred."

There were a few suggestions for a Federal program of adoption subsidy.

"We subsidize everything else including the military and the large farmowner so why should we not subsidize adoption—human commodity?"

The few respondents who disapproved or had mixed opinions about subsidized adoption expressed concern about the adoptive parents' motives. "One would have to be sure it was for love of the child rather than for love of the money."

Foster-parent adoptions. Less than one-third of the respondents mentioned adoption by foster parents. Those who did generally approved, but their approval was often qualified by reference to the need for individualized evaluation. No support was given to the rule some States have against allowing foster parents to adopt a child already in their care.

There were two main reasons for approval: (1) That adoption by his foster parents would bring the child a "real home of his own" and remove the threat of further placements; (2) that the foster parents' desire to adopt the child must mean they have learned to love him. A few respondents suggested foster care as a kind of trial adoption.

Qualifications of approval usually concerned differences in criteria for selecting foster and adoptive parents.

Older parents. Almost two-thirds of the respondents expressed no clear-cut opinion in regard to adoption by older persons, but among the opinions expressed more than five out of six were favorable.

Rather than a blanket policy (on age), each individual should be evaluated. There are people in their 60's much better able to be parents. . . . I was raised by my grandparents.

Most of those who approved, however, pointed out that by "older" they did not mean "really old", but merely older than the age agencies usually consider appropriate. Some said "not over 50," the age at which many people first become grandparents.

Many respondents pointed to the importance of considering the adoptive parents' health, energy, and the ability to "think young," and of their having available close, interested relatives to serve as an extended family for the child.

Recruiting adoptive parents

Most of the respondents offered a good deal of advice on how to recruit more adoptive applicants, some from direct experience.

The mass media. Use of the mass media—television, radio, newspapers, magazines—was by far the most frequent, and often the only, method or recruit-

ment mentioned. Two main functions were emphasized: (1) moving people to apply for an adoptive child; and (2) spreading information relating to the magnitude and the urgency of the need, the dispelling of "myths" about adoptive families and adoptive children, and the dispelling of misconceptions about agency policies and practices with regard to adoption. Television was the preferred medium.

However, a small proportion of the respondents, expressed the opinion that the effort and expense of such a campaign is out of proportion to the number of placements actually achieved. They pointed out that when shortage of staff and funds prevent a quick followup of the greatly increased number of inquiries, applicants tend to drop out.

In the recruitment campaign we got over 100 inquiries and completed about five home studies.

Several respondents suggested that mass media appeals to be useful must be carried on in conjunction with more direct person-to-person contacts.

Personal contact. About one-fourth of all the respondents emphasized the value of a personal approach in some form. Some favored using a full-time recruiter, preferably black. Others suggested involving paraprofessionals from a poverty agency.

There are many potential adopters being missed in low-income groups. Agencies need to get out and talk to the black people . . . The emphasis must be on reaching the people where they are.

Adoptive parents. Many respondents, including some adoptive parents, suggested the use of adoptive parents as recruiters. Some cited instances in which the example of happy adoptive families has stimulated friends and acquaintances to seek adoptive children. Others recommended group meetings in which adoptive parents tell about their own rewarding experiences. A community representative suggested having new applicants meet with an adoptive parent after the first interview "to relieve the tensions."

Almost as many opposed as approved attempts to involve adoptive parents in recruitment efforts, usually because they had found, or believed, that this is regarded as an invasion of privacy.

Community approaches. Churches and other local organizations and community groups were frequently

mentioned as channels for recruitment efforts. Respondents with direct experience were more pessimistic than others about recruitment through churches. Those who endorsed such efforts said that clergymen could help to dispel some deterring myths. The skeptics said that church appeals have not produced results because (1) they have been "one shot events rather than sustained programs; (2) they have been directed toward middle-class congregations; (3) they have relied on posters or brochures rather than person-to-person contacts.

Opinions were divided about the usefulness of setting up local committees to stimulate recruitment efforts—the division apparently being based on differences in experience. Among local groups cited helpful were fraternal organizations, PTA's, industrial firms, professional associations and unions.

Coordination and collaboration. A recurrent theme in the recruitment recommendations, especially those with direct experience, was the need for planned, sustained, coordinated methods employed by cooperating agencies, groups, and individuals. The most enthusiastic success stories tended also to involve sustained, coordinated efforts *within* agency modification of deterring practices; and preparation to cope with increased applications.

A major block to effective coordination, some experienced social workers said, is lack of trust between agencies and the unwillingness of some to accept work done by another agency. They saw a need for "true community of agencies" on the local, State, and national levels.

The message

Thus, the major message delivered by these respondents was a plea for more "integration" in a special sense: through broadening the definition of potential adoptive parents to include groups and individuals formerly left out of consideration; and through combining various methods of recruitment in a planned, sustained, and truly coordinated effort.

¹ Herzog, Elizabeth; Sudia, Cecelia E.; Harwood, Jane: Families of black children: the search for adoptive parents. U.S. Department of Health, Education, and Welfare, Office of Child Development, Child Welfare Bureau. 1971.

INNOVATIONS TO IMPROVE CARE IN AN INSTITUTION FOR THE MENTALLY RETARDED

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We passed through the nursery. Attendants were changing diapers. We watched one of the attendants. Mechanically, she lifted the child forward by holding on to both legs, flipped him over, put on fresh overalls, flipped him on his back, pulled him forward, and went on to the next without a smile, pat, or even a touch. The children's eyes seemed dead. Had nothing ever stirred them to life? But, no one seemed to have time to find out. Perhaps it was because there were so many to be cared for by so few.¹

Thus Nancy Faber has described what she observed in a nursery of an institution for the mentally retarded. The situation she described, however, is not unique. Similar ones could be found in many institutions for the retarded in this country, and not only in their nurseries but also in some of the cottages or wards for their older residents.

One does not have to be a research scientist to find that retarded children are often considered unresponsive to the kind of attention given to "normal" children and, therefore, are subjected to a sterile environment. When attempts are made to remedy such a situation, the innovator must contend with traditional institutional philosophy, negative attitudes, a

paucity of trained personnel, and employees who do not understand the needs and potentials of children.

To overcome these obstacles to improvement, the Sunland Training Center at Miami—Florida's newest State institution for the retarded—has instituted a training program for children and staff members. The program is called the BKR experiment for its three originators, Louise M. Bradtke, William J. Kirkpatrick, Jr., and Katherine P. Rosenblatt—coauthors of this article.

The Sunland Training Center was established in 1965 to provide retarded persons with opportunities for growth through comprehensive services—diagnosis, evaluation, medical and health treatment, recreation, training, education, and habilitation. To enhance the effectiveness of the training and treatment programs, 36 homelike cottages were constructed. Each cottage houses 20 children, except for the nursery, which houses 60 children. The institution's facilities also include a shopping center, a chapel, two schools, a sheltered workshop, an infirmary, recreational facilities—gymnasium, swimming pool, ball field, picnic areas—a farm, a well-equipped diagnostic and evaluation clinic, and a day-care center for retarded children who live in the community. However, in spite of the institution's stated purpose and its modern facilities, in its early years Sunland's program for the more seriously retarded fitted Dr. Faber's description.

Late in 1967, faculty members of the University of Miami took part in a comprehensive evaluation of Sunland's program and problems. The study committee found that nearly all Sunland's programs and

services were aimed at its moderately or mildly retarded residents, while those who were severely or profoundly retarded received not much more than custodial care. In the committee's opinion, Sunland's effectiveness was impeded by its organizational structure and procedures, which were based on concepts applied in most large multipurpose institutions. These organizational concepts had emerged in the five decades from 1850 to 1900, rather than in the present era of planning and action on behalf of the retarded. Thus, without a modern pattern for an institution available, Sunland had established its basic table of organization on a slightly modified version of the traditional institutional model. Under the general direction of the superintendent there were four major sections, each including a number of departments. These sections and the departments they included were—

1. Administrative services: business office, central stores, food service, maintenance and operations, security, resident services, purchasing, property, and communications.
2. Programs and services: education and training, psychology, social services, volunteer services, diagnostic and community services, sheltered workshop, and recreation.
3. Cottage life: cottage life, adjustment cottage, and nurseries.
4. Medical services: medical service, nursing service, physical therapy, dental clinic, X-ray, pharmacy, outpatient clinic, laboratory, and hospital.

Each major department was responsible for providing services or programs to all residents although there were great differences among the residents in potential, functioning ability, behavior, and program needs. Thus, Sunland had become department-centered and in some areas, even profession-centered

rather than program- and resident-centered. As a result its programs produced improvement in very few of the residents. To make effective program opportunities available for all the retarded, the committee recommended change in the organizational structure of Sunland to create at least four separate but interrelated program divisions to provide intensive specialized treatment and training.

Reorganization

Therefore, Sunland applied for and got a Federal grant from the Social and Rehabilitation Service to develop a "horizontal" instead of a "vertical" structure for providing services. As a result, the former program sections and departments have been supplanted by four program divisions, each staffed by a director and an interdisciplinary team composed of professional and subprofessional staff members crossing former departmental lines to focus on specific resident-oriented goals: development and training; independent living; education and training; and vocational rehabilitation.

Each division team consists of the division director, a psychologist, a physician, a teacher, a social worker, two cottage group supervisors (day and evening shifts), individual cottage supervisors, cottage parents, recreation therapists, a nurse, cottage training instructors, food service workers, inservice training instructors, and other related staff.

An overall advisory team circulates on a "tea round" basis to each division once a week. It consists of the directors of the former major departments such as cottage life, psychology, social service, recreation, and medical. The advisory team evaluates the progress in the implementation of the programs, acts as a sounding board for staff proposals and ideas, gives consultation as needed in program areas, and aids in solving problems. The advisory team also meets quarterly with all four divisional teams along with the institution's superintendent, business office plant superintendent, and other key personnel to discuss the overall status of the institution in relation to its stated goals and objectives and to establish priority assignments.

Each resident is placed under the program division most appropriate to his needs. Each division is responsible for certain cottages, the number varying with the division. The residents are assigned according to their age, sex (after 12 years of age), functioning level, estimated potential, and specific management problems.

Arnold D. Cortazzo (right), is superintendent of the Sunland Training Center, an institution for the retarded at Miami. Louise M. Bradtke, William J. Kirkpatrick, Jr., and Katherine P. Rosenblatt are respectively staff training coordinator, director, and coordinator of community services for the BKR Project at the center, described in their article. The four coauthors are all on the faculty of the University of Miami.



Theoretically, there are many intermediary program planes between divisions. As residents develop in a program they may move up into other planes, and even, with continuing development, into another division. While the programs within divisions differ, no matter which division residents are in, they receive as much attention as residents in any other division.

The Development and Training Division serves profoundly retarded children of school age (7-21) who still need to learn the very rudimentary skills of daily living, such as toileting and self-feeding. Its program consists of a wide variety of behavior-shaping activities with the following specific goals: self-feeding; controlled toileting; self-dressing; purposeful self-locomotion; communication (learning commands, gestures, making needs known, and elementary language); brushing teeth; clusters of appropriate activities upon arising; clusters of appropriate activities around mealtime; clusters of appropriate activities around bedtime; and recreational and simple occupational activities.

The Independent Living Division serves residents 16 years of age or older who do not seem to have the potential for competitive employment, but who with appropriate training become sheltered employees either in a community workshop or in an institution. Most of the residents assigned to this division have already been trained to care completely for their own personal needs, such as dressing, feeding, and toileting, and can get by with a minimal-to-medium amount of supervision in most activities required in daily living. Many may eventually be able to live in the community in a group home for five or six retarded persons and work in a sheltered workshop or institution.

The Education and Training Division is responsible for eight cottages housing children between the ages of 7 and 16 and the nursery for preschool children, which has three wards of profoundly retarded children and one ward of children classified as "trainable" (IQ 35 to 50). Each ward accommodates 15 children.

This division emphasizes the development and use of language, motor skills, skills in the tool subjects (reading, spelling, and arithmetic), and social competency. It also provides information about occupations, prevocational training, homemaking, vocational guidance, and some in-school work experience. When residents pass the age of 16, they may continue in the Education and Training Division, or be transferred either to the Independent Living or Vocational Rehabilitation Divisions.

The Vocational Rehabilitation Division is for residents over 16 years of age who have the potential for competitive employment in the community. It includes four halfway houses located on the institution's grounds.

The BKR experiment

Soon after the initiation of the divisional program, it became evident that a new, bolder approach had to be developed for the very young profoundly retarded children. Even though the nursery was in the Education and Training Division, it had an unstimulating and unrewarding environment which hindered the growth of the moderately retarded child and fixated the profoundly retarded child in the bottomless depth of unawareness. Even those children who were in the school classes were left "to vegetate" on mats when they were returned to the nursery from class.

When asked why this was so, the cottage parents gave the following responses: (1) They had been told not to spoil the children; (2) their jobs, as outlined, were to clean and feed the children; (3) they had too many housekeeping chores to do; (4) there was not enough staff; and (5) some of the children could never learn, so "why bother?"

The cottage parents, who can be most influential

Individual attention, such as these two children are receiving from Sunland aides, is one of the keys of the BKR program.





A blind girl learning through sound and touch from a teacher's aide trained in the Sunland program.

with the children because of the time they spend with them, had been trained in all areas of residential care except in how to cope with behavior problems and how to train the children. Rather than being expected to act as surrogate parents, they were expected to act only as the children's caretakers or custodians. Such expectations had not only affected their own self-image, but also had limited the probability that the moderately retarded preschool children would carry over to their behavior in the nursery what they had learned in the classroom. Consequently, negative behavior that disappeared in the classrooms reappeared in the nursery and was reinforced by misdirected attention.

Because of this situation a consultant in special education from the University of Miami proposed that an experimental program be developed especially for preschool-age severely to profoundly retarded children. The result was the initiation of the BKR Experimental Project, with its two-pronged goal: (1) To demonstrate that a multifaceted learning program can effect change in the development of preschool children with multiple handicaps, including behavior problems; and (2) to train professional specialists and aides to work as a team in setting up, operating, and maintaining a program based on the functional needs of the retarded.

The project got underway in the fall of 1968. There was no difficulty in identifying children to fit its criteria for participation. They were the children whose potential had been left untapped—the profoundly or severely retarded toddlers who had been regarded by their attendants as not possessing any of the attributes necessary for learning and so had been labeled as “custodial cases.” The label tended to compound their neglect in all areas except bodily care. Even the most basic skills in self-feeding, toileting and dressing were considered by some staff members to be beyond these children's capabilities.

The overall strategy of the project provided focus to both the individual child and the attending employee. Attention to the child was focused on his individual behavior and learning problems regardless of the label that had been attached to him from birth. The objective of this part of the program was to prepare the children for participation in a formal type of an educational program. Attention to the attending employee was focused on re-motivation toward helping the child learn and retraining for achieving this objective.

From 1968 to 1969 the staff of the BKR project provided services for 60 profoundly retarded to moderately retarded children from the ages of 3 to 45 years, 45 of whom had been rejected from the center's educational activities because of their behavioral or intellectual deficits or both. The project staff realized that to diminish the effects of these handicaps and to provide a therapeutic environment, they would have to spend a great deal of time working with the children and their cottage parents. With this in mind, individual activity programs for children were designed to be carried out in the nursery wards as well as in the classrooms. To initiate the children's programs, however, the project staff had also to redirect the cottage parents' approach from mere physical care to an effort to help the child achieve the behavior necessary for better functioning. In general, the cottage parents knew the children better than the rest of the staff and sincerely wanted to help them. However, to do so, they needed to be given direction.

At the beginning of the project each child was seen individually by the BKR project staff to determine what skills he had for daily functioning. On the basis of this evaluation, specific behavioral objectives were established for him and a curriculum was designed to attain them. There was, for example, an 8-year-old boy who was confined to a restraining jacket because he kept poking at his eyes and scratching himself until he bled and who screamed constantly except

when left entirely alone. To reinforce acceptable behavior he was allowed foods he liked, such as sugar-coated cereal, only when he stopped screaming and trying to engage in self-destructive activities. After his procedure was begun, the screaming and the undesirable behavior decelerated rapidly. In a short time the restraining jacket was no longer needed.

Within the classroom all distractors were removed to keep the children's attention focused on the learning task. Specific techniques used to develop adult-child relationships included purposeful eye-to-eye contacts and the use of positive reinforcers. Because the children were grossly deficient in general awareness, acceptable social behavior, gross and fine motor skills, and perception, a very small child-adult ratio was essential, and, therefore, learning groups were kept very small. Within a year's time many of the children who had participated in these small learning groups had carried over what they had learned into their nursery behavior. This carryover was enhanced further by the training the cottage parents received.

Teacher's aides

The educational model as conceived required that there be additional staff members and that they receive explicit training in educational methods and procedures. But where were the additional staff members to be found? Because of the scarcity of persons trained professionally in the field of special education, it would have been unrealistic to try to increase the staff with professional special educators.² Therefore, it was decided to train some of the nonprofessional persons on the center's staff as teacher's aides who would work with small groups of two to four children under the supervision of professional teachers. It was also decided to undertake the challenging task of training "rejected" staff members to work as aides with "rejected" children.

The six staff members transferred to the project for training as teacher's aides were selected because they had been having difficulties as cottage parents, recreation workers, or cottage training instructors getting along with immediate supervisors or fellow workers or in conforming to regulations. Their educational attainment ranged from completion of a year of junior college to only a year or 2 of high school. Their ages ranged from the low 20's to mid-40's. The length of time they had been employed at the center and elsewhere varied from several months to several years. But they had one thing in common—they had not

been successful or accepted in any of their previous assignments.

The BKR project developed an intensive 5-week training program for the aides. It emphasized concrete, practical experiences designed to build the appropriate attitudes and technical competencies necessary for meeting the physical, learning, and social needs of the children.

The training program began with a 1-day orientation on the purposes of the BKR project, the aides' role and functions in working toward its goals, the general principles of behavior modification, the needs of the children, and the relation of needs to environment. Following this session the aides were taught how to make accurate observations of children's behavior in the different environments of the center. Their observations became the basis of planning and programming for the children.

To build proficiency in observation, each aide was assigned to watch one child's behavior closely for several 5-minute periods. In doing so, the aide recorded her observations of simple, specific acts on a special form as often as the acts occurred. Between each of the observation periods, the aide and her instructor held a thorough discussion of the events witnessed, in an effort to reduce the probability of error and to reinforce accurate observations.

Sometimes the aides used mechanical counters to record their observation of each act. For example, an aide was instructed to record the number of times a child, Bobby, banged his head with his hand during several 5-minute periods. Each time Bobby banged his head, the aide pressed his counter. In one 5-minute period Bobby banged his head 40 times.

The training in observation proceeded from concentration on the easily perceptible types of inappropriate behavior in one child, such as Bobby's head-banging, to increasingly complex and subtle manifestations of difficulty or potential difficulty in the actions of at least two children. Eventually, the aides were also trained to describe evidence of ability in a child in such areas as social and motor behavior, reaction to materials used, and responses to reinforcers. Throughout the entire training period the aides were required to attend to the form and content of their reporting so that the data they gathered could be used by other members of the staff.

At first the aides observed the children only from a specially designed observation room, which faces the classrooms. However, as the program moved into the second and third weeks, they moved to the cottages and other settings to observe at least two chil-

dren and a staff member in various kinds of activities. During the fifth and last week of the training period, the aides were given opportunities to observe children wherever they chose, applying the techniques they had learned.

In addition to being trained in observation, the aides were shown how to use training materials made or adapted especially for the children from the nursery. This part of the training was usually done through the use of prescriptive cards. The aides first selected a "problem-defining card," which spelled out a problem and suggested the general type of program activity most appropriate for the child. Then with the aid of the supervising teachers, the aides selected a "program-activity card" prescribing a specific activity to meet the problem described on the first card. For example, if the first card defined the child's problem as "a poor grasp", the second card would suggest a simple method for helping the child to hold onto something.

The aides were not expected to learn about the etiology or various manifestations of mental retardation, but they *were* required to adhere to the following guideline: "This is a child; this child has difficulty in learning. How can I help him?"

Thus, labeling was discouraged. Emphasis was placed on the idea that because all children are different from one another, regardless of the type of learning problem they may have, each adult-child contact must be made on an individual basis. At the same time children's common needs were also emphasized. Every afternoon during the training period consultants from the university conducted seminars on child development and child management. Subjects included motor, social, emotional, language and intellectual development, the normal behavior of young children, behavior management, material construction and utilization, and evaluation of a child's ability.

All the aides participated in all parts of the training program. However, each aide was allowed to move at her own speed in the direction she functioned best. Throughout the training, aides were encouraged to work with children in areas in which they demonstrated the most empathy and strength. Some aides worked better with certain children in specific kinds of activities and with particular types of materials. The BKR project found that the appropriate way to improve an aide's performance was to modify the role to fit her special abilities while insisting that she develop the same basic skills as the others. For example, an aide who was especially skilled in making

certain kinds of activity materials had trouble working with small groups of children. Therefore she was assigned to work in a one-to-one situation only with the particular children she worked with well.

Video tapes, made available by the university for recording changes in both the aides and the children, proved valuable in evaluating the training program, analyzing the training methods for the teaching staff, and pointing out to the trainees the effective use of methods and materials with children.

Twenty employees whose work was not previously considered satisfactory have completed the aid training program and are now successfully performing their functions with the children. Eight of them are serving as cottage parents and 12 as aides. Thus the BKR Experimental Project has demonstrated that nonprofessional personnel can be trained to a level of sophistication that will benefit rejected children. A total of 35 of the original 60 children accepted into the project have developed to a level that they are now enrolled in the Sunland's formal educational program.

The population in the BKR project still includes all the children living in the nursery at Sunland but it now also includes 20 children who live in the community. Beginning in June 1969, with help from the Office of Education, the program has been expanded to provide the same kind of help to severely retarded children living outside the center by training their parents in behavior management principles and techniques. With this kind of assistance in learning how to care for their retarded children at home the parents may be able to defer institutionalization of these children. During the training the parents undergo a modified version of the aides' training schedule. When ready, they are assigned a child of their own to work with in the classroom, because it has been found that in the beginning parents are able to work with children other than their own more objectively. Later on they are assigned specific tasks to accomplish with their own children.

Volunteers are being similarly trained for working in various parts of the center.

Thus, Sunland is following through with its determination that no child within its reach, no matter how retarded, shall be treated as a hopeless "custodial" case.

¹ Faber, Nancy W.: *The retarded child*. The Crown Publishing Co. Inc., New York, N.Y. 1969.

² Cortazzo, Arnold D.; Orkin, Kenneth H.: *The mental retardation technician program at Miami-Dade Junior College*. *Mental Retardation* February 1970.

Minorities Achieve the Right To Question Achievement

CECELIA E. SUDIA

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What are the rights of a racial minority group that is being "researched" in regard to achievement?"

Does the group have a valid interest that should be recognized in determining who gets studied? or how the study is conducted? or who is funded to do the study? or to whom and how the results of the study are disseminated?

Do the people under study have the right to expect some positive return for their cooperation in being studied?

If social scientists from the group being studied are the best qualified persons to study their own group, how can they get the proper credentials if all study committees are composed of persons from the white majority?

Should there be academically "qualified" minority members on all study committees of Government agencies such as the National Institutes of Health, the National Institute of Mental Health, the National Science Foundation, or the Office of Child Development? Should there be minority group committee members even if they are not academically qualified?

These and other equally difficult questions were discussed at length, and sometimes with heat, at a 2½-day "by invitation" conference held at Children's Memorial Hospital, Chicago, April 19-21. The meeting was sponsored jointly by the Children's Memorial Hospital-Northwestern University Medical Center, the Division of Research Grants of the National Institutes of Health, the National Institute of Child Health and Human Development, and the National Institute of Mental Health.

Jerome Schulman, head of the department of psychiatry at the hospital, and Harry Crockett, professor of sociology at the University of Nebraska, served as cochairmen of the conference. The conference began with three complete types of meals being made avail-

able at the same time (Mexican, Chinese, and soul food) with the rather overwhelming expectation that the conferees partake of each.

The participants were somewhat haphazardly representative of government, academic research, and the various racial minorities. In fact, many of the participants were two hats, representing both a minority group and government or academic institutions. Of the 60 or so participants about half were members of minority groups and about half were government employees. About a third of the total were university staff members and about a fourth were spokesmen for minority groups who were not also employed by either a university or a Federal granting agency.

Strong questioning

The original intent of the conference apparently was to recommend appropriate research to NIMH study group committees in regard to achievement in U.S. minority groups. However, the loose structure and the combination of persons present resulted in strong questioning of the whole structure of Federal funding of research as it relates to minority groups.

On the first full day of the conference, the participants were assigned to work groups charged with defining "achievement" as it exists in American society and as it applies to minorities. Some groups surveyed current research on achievement and discussed the determinants of achievement in children and in adults. Others considered the goals, methods, and efficacy of intervention programs, and finally, whether there is evidence for genetic differences in achievement between different racial groups.

This last subject involved the participation of Psychologist Arthur P. Jensen, of the University of California

at Berkeley, author of a controversial report on the implications of hereditary differences for planning compensatory education for black children.¹ Some invited participants, notably Ernestine Thomas of the American Association of Black Psychologists, had refused to attend the meeting because of Dr. Jensen's presence. However, that organization was ably represented by Stanley Crockett of LaJolla, Calif.

Several definitions of achievement were proposed. One discussed at length was that of Elliot Liebow, director of NIMH: Achievement is that which entitles you to the respect of your peers or other people important to you.

This definition allows for respect to be based on something other than occupation and income—the most commonly used criteria. However, most of the participants appeared to believe that, in most cases, income and occupation are still the crucial factors in earning respect. It was pointed out that the exclusion of members of minorities from jobs results to a large extent in excluding them from all other means of earning respect, either within the family or within the community.

Some participants expressed the opinion that survival itself has so preempted the attention of minorities that they have no time or energy for additional efforts. They strongly questioned the practice of measuring minorities on a pathology model, whether the model be cultural deprivation or family pathology. An NIMH psychologist, Edwin Nichols, presented an analysis of early American settlers and the consequent development of American cultural values, philosophy, ethics, and so forth, on a pathology model, which not only demonstrated to whites present just how it feels to have one's cultural values presented in this way, but also offered some exciting possibilities for analysis concerning what is wrong with white America's values and why.

Why don't social scientists study the qualities that have enabled the black families to survive? What are the great strengths of the black family in America?, asked Cecile Mellardy, African-born anthropologist. Are these not qualities which might be most useful to the whole society?

The ample evidence that the youth of this country are questioning the white male achievement model, as it is presented to them, was also considered, as

was the contradiction in the current cultural values of "making it" and "doing your own thing." Many white middle-class young people, as well as members of the minority groups, are challenging the legitimacy of the "making it" norm. Today, it was pointed out, the real issues are political: who determines, who referees, who legitimates an option?

Who should judge?

Another work group defined achievement as that level of attainment found acceptable by the majority culture in reference to economic, social, and educational behavior. Its members pointed out that achievement, such as graduation from a Negro college, has no meaning until it is validated by the whites, as when the graduate makes a passing grade on the Federal Service Entrance Examination of the Civil Service Commission. Similarly, nonwhite artists, musicians, athletes, and the like, have "made it" only after they have been recognized and applauded by a white audience.

Participants in another work group asserted that the value of proposed research on minority groups should be judged by the group involved. If the right to make this judgment cannot be established, there is no value in a conference to discuss such issues as achievement.

It was pointed out that a black community in the Boston area has recently refused to allow a \$2 million research and demonstration project, funded by the National Institute of Child Health and Human Development, to proceed because members of the community had not been consulted in advance and its spokesmen questioned the worth of the research to the people being studied or to the community as a whole.

The "establishment" people present ranged in their reactions to the discussion from anger and frustration to acceptance and approval. Apparently the task of explaining and justifying research to a defensive minority community seems challenging to some research workers and appalling or impossible to others. Some participants seriously questioned whether any research would be possible under such restrictions. However, it was pointed out that a section of NIMH has successfully set up in the same Boston com-

munity a project that was planned with the active cooperation of the Black United Front, thus giving some evidence that this way of approaching research is possible.

Minority group participants also stressed the fact that there is no unimodal or single view that characterizes any minority. Some participants attempted to present a classification that would indicate the range of opinion and values among blacks. These attempts were rejected by others as overly simplistic or simply inaccurate. Criteria suggested for such classification schemes included levels of group awareness, modes of group self-identification, and levels of power in relation to the white group.

The differing advantages and perspectives of the various minority groups came out clearly in the general discussion. The blacks have enough trained people and enough resources to present a demand that they be allowed to conduct research.² Other minority groups are not so well off.

Edward Cassavantes, U.S. Civil Rights Commissioner, speaking for the Chicano minority, reported that he had tried to set up a roster of Chicano social scientists and had been able to find only 45 who might be considered qualified to conduct research. "How does a group begin to begin?" he asked.

Even more powerless are the American Indians, who have long been the subject of more research than service. Last year, it was reported, the Indians on one South Dakota reservation were subjected to more than 63 separate research or demonstration projects.

In discussions of the types of research that would be most helpful to minorities in their efforts to attain full rights as human beings, the participants strongly recommended that color or race as variables in experimental or control groups be prohibited and that Federal funds be denied to studies making such distinctions. Within-group comparisons, they maintained, provide the kinds of information necessary for helping individuals or for designing intervention programs.

Present practices

Present criteria for selecting the members of NIH study sections and review committees were strongly criticized. While some participants defended

these criteria in terms of academic and professional merit, others advance substitute criteria.

At the present time, study group sections at NIH, NIMH, and other government granting agencies are essentially a cooperative effort between the agencies and leading university social scientists. The guiding concepts are that the best research proposals should be funded, and that the determination of "best" should be made by a jury of research workers from top universities engaged in the same sort of research. Readers of *Science* would know that the criticisms voiced at the Chicago meeting were not the first to be leveled at this rather tidy system which regularly funds well-known professors at the "have" universities and overlooks others at the smaller less prestigious colleges and universities, white or black. For instance, Congress has asked the Government agencies why research grants are distributed heavily on the east and west coasts and whether this geographic distribution actually reflects the distribution of research competence.

The have-not academic circles have also complained, but they are vulnerable in that their social scientists subscribe to the same status rating system and so have difficulty maintaining the unmerited discrimination has in fact occurred.

Members of the conference in Chicago asserted that knowledge gained through membership in a group is a special kind of knowledge that should be recognized as a pertinent criterion in selecting membership for research committees. At least one NIMH center has a nonprofessional person on its research review committee.

Another NIMH center has recently required the first member of a minority race on its advisory committee. On the other hand, NIH study committees are vulnerable to criticism because they do not even have token minority representation.

Some participants pointed out that research that compares racial groups can be very damaging as long as the country is a racist society. Consequently, they recommend that the academic community should proceed cautiously in this respect, consider the potential misuse of the project be considered, and weigh the value of scientific contribution against its po-

ble dangers. The person who undertakes such research, it was suggested, is ultimately responsible for any harm that may result from it.

The conference also discussed the problem of getting "informed consent" from the subjects of the research. While this is now required in medical research,³ there is difficulty with its implementation even there. The problem of getting the informed consent of a group, or even the question of what this might be, has not really been considered.

In the last part of the general discus-

sion, attention was focused on Dr. Jensen's current research, which has not yet been published. It was soundly assailed by many participants, but the dialogue remained largely on two divergent levels. Dr. Jensen advocated a eugenics program where genetic counseling and birth control would be used to restrict birth among any intellectually inferior individuals, but he did not specify whether this would be voluntary or involuntary or how it would be implemented. Such a proposal is abhorrent to many people and was strongly condemned as genocidal by

most of the participants, whites as well as members of minority groups.

A complete report of the conference will be published in the near future.

¹ Jensen, Arthur R.: How much can we boost IQ and scholastic achievement? *Harvard Educational Review*, winter 1969.

² Federal agencies and black colleges—a report produced by Federal Interagency Committee on Education. 1969. Revised 1971. Available from HEW Information Office.

³ Lewis, Melvin; McCollum, Audrey T.; Schwartz, A. Herbert; Grunt, Jerome A.: Informed consent in pediatric research. *Children*, July–August 1969.

guides and reports

EARLIER RECOGNITION OF HANDICAPPING CONDITIONS IN CHILDHOOD. Proceedings of a Bi-Regional Institute. University of California, Berkeley, Calif. 94720. 1970. 159 pp. Single copies free from the University.

Contains 18 brief papers on such subjects as genetic counseling, the biochemistry of handicapping conditions, various aspects of screening procedures, severity as a handicapping condition, and the delivery of health services.

HELP FOR DAY CARE WORKERS: A lap to sit on and much more. Monroe D. Cohen, editor. Association for Childhood Education International, 3615 Wisconsin Avenue NW., Washington, D.C. 20016. 1971. 96 pp. \$2.

A collection of articles from *Childhood Education*, providing some principles for working with children in various kinds of day-care settings.

GROUP INFANT CARE PROGRAMS: A survey. Marion Howard. Cyesis Programs Consortium, George Washington University, Room 505, 1145 19th Street NW., Washington, D.C. 20036. 1971. 108 pp. Single copies free on request.

Describes 59 programs that provide

group day care for infants from birth to 2 years, 11 months of age; 26 connected with programs for pregnant school-age girls; 22 in Parent and Child Centers; and 11 operated by other agencies.

INNOVATIONS IN TEACHING SOCIAL WORK PRACTICE. Edited by Lilian Ripple. Council on Social Work Education, 345 East 46th Street, New York, N.Y. 10017. 1970. 89 pp. \$3.

Includes papers presented at the Workshop on Current Directions in the Teaching of Methods of Social Work Practice held in Cleveland, Ohio, in March 1969, cosponsored by CSWE and the School of Applied Social Sciences, at the Case Western Reserve University, Cleveland.

THE CONSUMER BEHAVIOR OF CHILDREN AND TEENAGERS: an annotated bibliography. Compiled by Robert O. Herrmann. Bibliography Series No. 16. American Marketing Association, 230 North Michigan Avenue, Chicago, Ill. 60601. 160 pp. 1970. \$3 members, \$5 nonmembers.

Abstracts reports from a variety of publications on the culture, problems, interests, and consumer habits of young people today.

THE COMMON BASE OF SOCIAL WORK PRACTICE. Harriett M. Bartlett and Beatrice N. Saunders. National Association of Social Workers, Inc., 2 Park Avenue, New York, N.Y. 10016. 1970. 224 pp. \$4.

Presents ideas and questions in relation to the professional practice of social work, analyzing trends and the movement toward a common base in practice.

TEACHING SLOW LEARNERS THROUGH ACTIVE GAMES. James H. Humphrey and Dorothy D. Sullivan. Charles C Thomas, Publisher, 301-327 East Lawrence Avenue, Springfield, Ill. 62703. 1970. 184 pp. \$8.50.

Presents methods of identifying slow learners, discusses the use of games in education, and describes more than 200 active games suitable for helping children learn reading, mathematics, and science.

ONE MILLION CHILDREN: a national study of Canadian children with emotional and learning disorders. The Commission on Emotional and Learning Disorders in Children, 165 Bloor Street East, Toronto 5, Canada. 1970. 521 pp. \$9.50.

This publication reports on the findings of a 3½-year study by a Canadian commission established by six national voluntary organizations of the existing services for the 1 million Canadian children who have emotional and learning disorders, and makes recommendations.

HERE and THERE



Inter-American Institute

A decline in national commitment to human services was identified by the Executive Council of the Inter-American Children's Institute meeting in Asuncion, Paraguay, May 17-20, as the most critical problem in projecting the Institute's program in the fields of health, education, social services, juvenile delinquency, and mental health. Found next in importance as serious problems were: (1) A declining commitment to services for the rural poor, caused by preoccupation with urban development; and (2) the difficulties youth face in finding constructive and satisfying roles in society.

Since 1927, the Institute, a branch of the Organization of American States, has served as a center of information, documentation, consultation, training, and social action relating to the well-being of children and families in the Western Hemisphere. Delegates from 20 nations attended the Executive Council's meeting. Martin Gula of the Office of Child Development was the delegate for the United States.

The delegates authorized the Institute to sponsor a series of training courses and seminars during 1971-72 on the following topics:

- Organization of health and social services for mothers and newborn babies.
- Function of juvenile judges and administrative agencies in helping youth in trouble.
- Children with mental retardation.
- Organization of child development-family orientation centers for parent education.
- Nutrition standards for children and families.
- Pilot centers for study of delinquency prevention and treatment.

The Institute will also sponsor a Pan American Child Congress to be convened at Cochabamba, Bolivia, in 1972 under the theme "Comprehensive Protection for Children and Youth in Jeopardy."

Nutrition survey

A survey of the nutrition levels of families living in low-income areas in eight States and New York City conducted by the Public Health Service between 1968 and 1970 found that 20 percent of the 2,636 children under the age of 6 years who were tested probably were suffering from iron-deficiency anemia, according to a preliminary report submitted to Congress in April 1971. The report points out that while children under 6 are at the greatest risk of this deficiency, iron-deficiency anemia is a major problem in most segments of the population.

The report also gives findings of a larger survey covering 83,597 persons in California, Kentucky, Louisiana, Massachusetts, Michigan, New York State, South Carolina, Texas, Washington, and West Virginia, and New York City. The 10-State survey found that families with incomes below the poverty level are almost twice as likely as families with higher incomes to be malnourished in three essential nutrients—iron, vitamin C, and riboflavin. However, the report notes that in most of the groups studied on the basis of age, race, sex, educational level, and income level, the percentage of persons having adequate caloric intake was similar for the poor and the more affluent. Among the exceptions cited were the adolescent poor in Louisiana, whose caloric intake was termed "potentially inadequate."

According to the report, children have less vitamin A and riboflavin in their

diets than adults; 15 percent of the children under 10 years of age had deficient or low levels of vitamin A and 17 percent of the children under 17 had deficient or low levels of riboflavin. Although there was great variability with in groups in the heights and weights of the preschool children surveyed, the survey found that children in poor families were generally shorter and weighed less than children in higher income families.

("Ten-State Nutrition Survey in the United States, 1968-70," Center for Disease Control, Atlanta, Ga. 30333.)

Residential care

A lack of community child welfare resources throughout the United States moves many children into institutions contrary to the best interest of the child, according to a comprehensive study of residential care conducted for the Center of Urban Studies of the University of Chicago. For example, the investigators—Donnell M. Pappenfort, School of Social Service Administration, University of Chicago, and Dee Morgan K. Patrick, Graduate School of Social Work, University of Denver—found that 37,000 children were placed or retained in residential institutions in a 1-year period because suitable foster homes were not available. Another 36,000 were placed or retained because more appropriate group or institution placements were not available.

On April 29 and 30 some 20 experts in child care and development convened at the University of Chicago to discuss the implications of these findings. They pointed to the importance of strengthening child welfare services and resources, strengthening the child development aspects of residential care, and eliminating the use of institutions as "wastebaskets."

The study includes information about the programs, services, and resources of 2,318 public and voluntary institutions that served 155,905 children and young people in 1966. Findings have been compiled in a seven-volume series, "A Census of Children's Residential Institutions in the United States, Puerto Rico, and the Virgin Islands: 1966" published as Social Service Monograph No. 4, Second Series, by the School of Social Service Administration.

Volume I, an introduction to the study, is entitled "Seven Types

institutions." Other volumes deal with specific types of institutions: II, dependent and neglected children; III, pre-elinquent and delinquent children; IV, emotionally disturbed children; V, psychiatric inpatient children's units; VI, maternity homes; VII, detention facilities.

(School of Social Service Administration, Publications, 969 East 60th Street, Chicago, Ill. 60637. Price: cloth, \$25 per set or \$5 per volume; paper, \$15 per set or \$2.75 per volume.)

Unmarried mothers

Increased availability of birth control information for unmarried adolescent girls in San Francisco has helped reduce the rate of second pregnancies among such girls, according to the findings of a followup study of 158 girls who gave birth out of wedlock in 1962, 1963, or 1966 at the age of 17 or younger. The study was carried out during 1968 and 1969 by the Maternal and Child Health Program of the University of California School of Public Health in Berkeley with Federal support from the Children's Bureau and the Maternal and Child Health Service of the Health Services and Mental Health Administration. It involved interviews with 76 girls who gave birth to a first child in 1966 and 82 who gave birth to a first child in 1962 or 1963.

The findings showed that within 2½ years after their first child's birth, 36

percent of those whose first child was born in 1966 had had a second pregnancy as compared with 59 percent of those whose first child was born in 1962 or 1963. Between 1963 and 1966 hospitals in the area changed their policies to include birth control services as a routine part of post partum care.

More than four times as many girls in the 1966 group received advice about birth control on post partum visits as girls in the 1962-63 group—73 percent and 17 percent respectively. After more recent pregnancies, however, more than half the girls in the 1962-63 group received such information.

Of the 158 girls, 100, or 63 percent, had had at least one subsequent pregnancy by the time of the followup interviews. About 28 percent of these pregnancies occurred within marriage in each group. At the time of the interviews 56 girls were married and living with their husbands, 29 were separated, widowed, or divorced, and 73 had never married. Thirty-three had married the father of their first child. Eighty-two girls, or 51 percent, said they wanted another child.

Most of the girls told the interviewers they had not wanted their first pregnancy and had lacked knowledge about reproduction processes when they had begun having sex relations. Only two of the 48 girls who were 15 years of age or younger and 13 of the 110 girls who were 16 or 17 said they had "known enough" about sex at the time.

Ten of those in the younger age group and 38 in the older group said they had wanted to become pregnant.

At the time of the interviews, 85 percent of the girls said they believed in birth control for themselves.

The study, which also gathered data on the girls' health care, socioeconomic status, family relationships, and educational achievements, is part of a long-range investigation of out-of-wedlock pregnancy in San Francisco, under the direction of Helen M. Wallace, M.D., professor of maternal and child health.

correction

The editor apologizes to the Council of National Organizations for Children and Youth for an inaccuracy in reporting the plenary session sponsored by the Council at the 1970 White House Conference on Children. ("Selecting Priorities at the White House Conference on Children," by Kathryn Close, CHILDREN March-April 1971.) Rather than being unrecorded, as the article intimates, (page 46), resolutions at that session were taped, along with the rest of the proceedings, and are included in a report being published by the National Committee on Children and Youth under the title "Concern for Children". (Price \$2.50 from the NCCY, 1145 19th St., N.W., Washington, D.C. 20036.)

READERS' EXCHANGE

GALLAGHER: black adoptions

Thank you for carrying Ursula Gallagher's article on black children in need of adoptive parents. ("Adoption sources for Black Children", CHILDREN, March-April 1971.)

So much of the article agrees with what I have been saying that for a

while, my executive director thought I had written it. Presently, I am taking leadership in the Nashville community to recruit black parents for children who need them.

I do want to say that there should be an end to the "big pitch" for trans-racial adoptions. In my communities, Nashville being one of them, there is a

very important, untapped resource—the black community itself.

Consequently, I strongly urge the Open Door Society in Montreal, the Council on Adoptable Children, Opportunity, and other such agencies to stop fooling themselves that there is something healthy about white parenthood for black children and to refocus their energies toward actively recruiting for black parents.

The truth of the matter, as I see it, is that it would make all the difference in the world if white children were not moving into adoptive homes. Adoption

agencies would become innovative and would reach outside their doors to recruit families for 40,000 white children.

Until social agencies come to place the same value on black children as on white children, it would be better if they did not accept black babies for placement.

Louie M. Beasley

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Black and white

In her article, "Adoption Resources for Black Children," Ursula M. Gallagher outlines some of the still embryonic policies that finally permit black children to be placed in families that want a black son or daughter. However, she does not address herself adequately to the practices and prejudices that prevent agencies from placing all, or even most, black children in loving families. Nor does she indicate the relevant questions that should be probed by adoption agencies and prospective white parents who are considering adopting a black child.

I was amazed to find recently that one of the most prestigious adoption agencies in New York City has two separate fee scales for adoption, depending on the child's color. White children can "cost" up to \$2,000 while the fee scale for black children only goes up to \$400 irrespective of the race of the adopting parents. Are black kids worth less than white ones? Do white parents need financial inducements to adopt a black child?

Furthermore, why are most of the black children who are adopted by white parents relatively light complexioned? This has been true, at least in those mixed racial adoptions I know of personally, including my own. If adoption agencies believe that a light skin makes it possible for the black child to blend into the white world more easily, they are implicitly sanctioning the elimination of that which is black in the child.

Virtually all the people on the boards and staffs of adoption agencies are white. They do not involve black people in policy formulation or in day-to-day programing. They do not know the black community; they insist on doing "business as usual" and then are surprised when they find they cannot

recruit black families for adoption. They do not reach the black community because they do not know it, and they perpetuate their ignorance because, actually, they do not care about placing black children.

The questions Miss Gallagher raises for white parents who want to adopt black children also reflect a "business as usual" perspective, for they focus on how well the couple will fare in their white society after they bring home a black child. She never asks how the white couple will try to insure the black child's comfort in his blackness or his ability to live in a society in which black and white are polarized or to live in a black community when he grows up.

Will the family (white parents and black child) live in a black community? Will the child have at least some minimum contact with a black church or a black community recreation center? Will he know "soul food" restaurants? Will he know a wide variety of black men and women who work in a variety of occupations? Will most of his playmates be black? When traveling will he know black communities or will he only know the white areas where members of his parents' families live or white downtown or resort areas? How will the parents feel when enmeshed in, or least intermingling with, black people in black communities? Indeed, what are the white parents likely to do to insure that the child has maximum exposure to black people, experiences, and perspectives?

Perhaps it would be helpful if adoption "experts" recognized that in our society a child with even one black biological parent is indeed a young black person and his value and worth cannot be negated by the use of euphemisms such as "mixed black and white child."

Roger Kahn

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Author's response

It may be true, as Mr. Kahn says, that prejudices of adoption agencies deter many black children from being adopted by white families. However, it is not always prejudice that keeps applicants from receiving a child. Since the focus must be on the well-being of the child, an agency would be remiss if it were to enter into a transracial placement without considering both

the strength and weakness in the particular white applicants' potential for helping a black child feel secure as a truly accepted member of their family and for preparing him to live in our society. The questions I have suggested are specific to this point.

As I have indicated, transracial placements of black children are controversial. There are both black people and white people who adamantly declare that a child's best interests will not be met through such a placement because of identity difficulties. Mr. Kahn apparently missed my statement regarding the importance of providing opportunities for a black child to know other black persons. For example, "... his parents must provide opportunities for him to establish his identity through learning about and meeting other black people whom he can admire."

If it is true that transracial adoptions involve more light than dark children, this is most likely because of the adoptive families' requests. Most agencies consider the wishes of the prospective applicants in respect to the child to be placed; if not, unhappiness could result for the child.

Fee charging is a common practice among voluntary agencies. The prevailing practice is to charge the adoptive parents for the service rendered, justifying fees to the ability of the adoptive parents to pay, but not according to any circumstances regarding the child. I am as surprised as Mr. Kahn to learn of an agency that relates the fee to the type of child.

The term "mixed black and white" is used frequently in speaking of a child born of one black and one white parent. Mr. Kahn is right in insisting that the term not be used to detract from the value of blackness.

Ursula M. Gallagher
*Specialist on Adoption
Children's Bureau*

photo credits

Frontispiece and pages 123 and 140
White House Conference on Youth.

Page 131, Yale-New Haven Hospital
New Haven, Conn.

Pages 151 and 152, B. K. R. Program
Sunland Training Center, Miami, Fla.

U.S. Government Publications

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SELECTED REFERENCES FOR SOCIAL WORKERS ON FAMILY PLANNING: an annotated list. Compiled by Mary E. Watts. HEW, PHS, HSMHA, Maternal and Child Health Service. 1971. 28 pp. 35 cents.

The items in this revised bibliography are listed under the following headings: studies of attitudes about family planning, planning family planning services, examples of family planning services, vital work, information on contraceptives, family planning for teenagers, abortion, evaluation, and "other."

DERUTILIZATION OF WOMEN WORKERS. U.S. Department of Labor, Workplace Standards Administration, Women's Bureau. 1971. 25 p. 35 cents.

Includes among other data, figures

W refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; PHS, to Public Health Service; SRS, to Social and Rehabilitation Service; OE, to Office of Education; HSMHA, to Health Services Administration; Mental Health Administration.

showing the most severe unemployment among teenagers from 16 to 19 years of age to be among girls of minority races—nearly 28 percent in 1969. Boys of minority races had an unemployment rate of 21 percent; the rates for white girls and boys in the same age group were 11 and 10 percent.

WHAT'S NEW ON SMOKING IN PRINT AND ON FILM. HEW, PHS, HSMHA, National Clearinghouse for Smoking and Health. PHS publication No. 1710. 1970. 12 pp. 10 cents.

Lists educational materials on a variety of aspects of smoking and health, directed to young people and adults, smokers and nonsmokers.

SERVICES FOR CRIPPLED CHILDREN. HEW, PHS, HSMHA, Maternal and Child Health Service. 1971. 20 pp. 20 cents.

Explains, through a question-and-answer method, what the Federal-State program for crippled children is, what it does, and how.

RESPITE CARE FOR THE RETARDED: an interval of relief for families. HEW, SRS, Rehabilitation

Services Administration, Division of Mental Retardation. 1971. 21 pp. 25 cents.

Discusses deficiencies in planning for continuing care for the retarded, such as plans for meeting emergency needs, restoring or maintaining physical and mental well-being, and initiating training procedures in or out of the home.

TEACH CHILDREN FIRE WILL BURN. HEW, OCD, Children's Bureau. Children's Bureau Publication 471. 1970. 24 pp. 20 cents.

Addressed to parents, gives the do's and don'ts for preventing fire hazards around the house and suggests a family plan for escape from fire and smoke when they do occur.

THE EFFECTS OF CHANGES IN THE STATE ABORTION LAWS. HEW, PHS, HSMHA, Maternal and Child Health Service. 1971. 28 pp. 35 cents.

Summarizes and discusses the provisions of State abortion laws, incidence of induced abortion, methods used, incidence of complications, fees charged, and availability of safe abortion services according to income groups.

REPORT TO THE PRESIDENT: White House Conference on Children 1970. May 1971. 452 pp. \$4.75.

Contains the reports and recommendations of the 25 forums of the 1970 conference, a delegate preamble, and results of delegate balloting.

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CHILDREN

INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

september • october 1971

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mothers as tutors of young children

play center for handicapped infants

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A autistic child responds to the teacher's warmth and spontaneity—an important advance toward "normal" development. Such development is one of the goals of the Edward Levy Infant Center in Pasadena, Calif. The center's program for developmentally handicapped infants is described in the article beginning on page 174.

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● One of the major changes in residential treatment centers in recent years is in their attitude toward the parents of children in placement.

In the past, children placed in institutions were often separated both physically and emotionally from their families on the theory that since the parents were the cause of the child's difficulties, contact between the child and his parents should be severed. Sometimes parents were promised that their child would be returned to them if they made appropriate personal changes. However, the institution rarely saw itself as the vehicle of treatment for the parents. Parents who wished to change were expected to get help from other community resources, but often such resources were not available. Consequently, few parents achieved the required change, and this fact reinforced the widespread opinion that such parents were "unchangeable."

Gradually, however, the more progressive institutions began to experiment in helping parents achieve change and maintain parent-child relationship. Their early attempts in this direction included parental visits to the institution on holidays, supervised letterwriting from the child to the parents, conferences between the parents and the social workers. Gradually more and more institutions adopted such practices. The innovations had some liabilities, however. Often the children were overactive, anxious, and disobedient on the Monday following a Sunday visit with their parents. Letterwriting time, which many institutions had expected to be a quiet hour filled with nostalgia, was punctuated by fights, arguments, torn paper, and broken pencils. Interpreting such behavior as a sign that even minimal parental involvement in the children's lives was detrimental, some institutions returned to their former policy of complete separation.

Other institutions, however, having expected this type of manifestation of already acknowledged conflicts between the parents and child, responded by mobilizing resources to help the family work through such difficulties. Today a growing number of children's institutions not only tolerate, but actively encourage, parent involvement in the institutional treatment program.^{1,2,3} They recognize that the child who makes a good adjustment to an institution is not necessarily prepared to cope with the demands of living at home.⁴

The practice of maintaining close family ties throughout the entire period of the child's placement

INVOLVING PARENTS in RESIDENTIAL TREATMENT of CHILDREN

KENNETH H. HEITING

In a residential institution is advantageous for the following reasons:

- It helps offset the child's fear of being abandoned and his feeling that he was sent away because he is bad.
- It helps keep alive the anxiety the parents have developed from feelings of guilt and failure in having placed their child away from home—anxiety that can be used in the treatment process to stimulate the parents to find new and more effective ways of interacting with their child.
- It keeps the conflicts between parents and child alive and so provides the treatment staff with specific types of behavior on which to focus in helping the child and parent effect change.
- It forces the detached, neglectful parent to acknowledge his responsibilities to the child,³ or, failing that, opens the way for steps to provide a substitute family for the child.

An evolving program

For these reasons the St. Aemilian Child Care Center in Milwaukee, Wis., where I am casework supervisor, has for the past 5 years been experimenting with ways in which to involve parents in the treatment of the children in its care. While the program is still evolving, we have found that in many cases it has helped children to return to more understanding homes.

St. Aemilian's is a private, nonsectarian treatment center for emotionally disturbed boys between the ages of 6 and 14, with a capacity of 37 boys in residential care and 15 in a daytime program. Both programs provide psychotherapy and intramural recreation and both expect the same kind of parental involvement.

Most of the children come from low- or middle-income families, but a few come from well-to-do families. Their disturbance is manifested in neuroses,

character disorders, and incipient psychoses. In some boys the disturbance has arisen from emotional or physical neglect, or both. In some it derives from minimal brain damage. All have at least average intellectual potential, however.

Since the majority of the families are unable to afford the cost of care, most of the children come to the center through referral from the Milwaukee County Social Service Department. The department pays the full fee, but requires partial reimbursement from the parents according to their ability to pay. Legal custody of the child is routinely transferred to the Social Service Department (to make it eligible for Federal matching funds) but parents continue to retain guardianship.

The Department of Social Services maintains close contact with the center in regard to each child. The center offers short-term aftercare services as needed. If long-term services are required, the department makes other arrangements.

When a child is referred to the center for treatment, the referral materials are reviewed by all of the staff members who will be working with him. Then the child and his parents are invited to tour the grounds with the caseworker or the child-care worker assigned to help the child. We have found that seeing the institution in this way often stimulates the family to discuss their fear of separation and their concerns about placement.

After the tour, the child and his parents participate in a preplacement conference, attended by the center's treatment coordinator and the front line staff assigned to the child—teacher, child-care worker, and social worker. The child attends the first half without

Kenneth H. Heiting has been with the St. Aemilian Child Care Center in Milwaukee, Wis., since 1964 as a child therapist and marriage counselor. He recently assumed the additional position of research coordinator. Mr. Heiting received his master's degree from the University of Wisconsin (Milwaukee) in 1964.





A father explains fundamentals of basketball to boys in his son's cottage at St. Aemilian.

his parents. He is asked to explain why he thinks his parents brought him for the visit, how the center differs from other schools, how he would feel about coming to it, and what he would like to change in his life. The anxiety arising in the child from such direct questioning stimulates him either to express his feelings frankly or to mobilize his defenses, thus giving the staff an opportunity to observe the way that he responds, whether by withdrawal, talkative evasion, or aggressive action.

The parents attend the second half of the conference with the child. The staff asks them to review their reasons for seeking help for their son. If they hold back for fear of hurting the child, they are urged to be frank and honest. We use this occasion to inform the parents that they are expected to work closely with the staff, to attend weekly or biweekly conferences with the child's social worker and monthly group meetings with other parents. They agree to have their child at home on regularly scheduled visits. We have found that generally parents welcome the opportunity to remain in close contact with their child and with the staff.

If the referring agency, the staff, and the parents agree on the suitability of placing the child in the center, one or two additional preplacement visits are scheduled for the child and his parents. On these visits the child spends several hours with his future cottagemates.

While he is doing this, the parents meet with the cottage parent, the social worker, or both, to discuss the details of admission and to complete the admission forms. Before leaving the parents are given some literature to take home containing answers to such

frequently asked questions as what clothing the boy will need, where he will get his hair cut, and who will provide medical care.

At the time of admission the parents, the representative of the Department of Social Services, and the center's social worker accompany the child to his assigned cottage. There they are welcomed by the child-care worker, who takes them to the child's quarters. In the past the child and parents would say goodbye at this point. We are now experimenting with having the parents remain while the child unpacks his clothes and gets settled in the cottage. In this interval the child-care worker has a chance to talk further with the parents and find out about the child's favorite foods, special interests, sleeping habits, and other idiosyncrasies; the parents have a chance to become better acquainted with the child-care worker and thus alleviate some of their anxiety about leaving their son with a stranger; and the child has the comfort of his parents' presence while he gets settled. Cottage staff members are enthusiastic about this innovation and the parents also seem to appreciate it.

Focus on the family

Both parents—if there are two parents—are required to attend casework therapy sessions with the social worker on a regular basis. These sessions take various forms depending upon the needs of the family—individual appointments, joint sessions with husband and wife, or family sessions including the child and his siblings. They may take place on a weekly, biweekly, or even monthly basis. In some cases

co-therapist—the child's houseparent or another social worker—regularly participates in the sessions.

While the social workers employ traditional casework techniques, they also use sociobehavior^{5, 6} and learning theory⁷ approaches that are focused on current behavior and its modification, often mixing various techniques in their work with the same family.

The center has arranged for the parent discussion groups to meet monthly in the relaxed atmosphere of each of the five cottages, under the leadership of the cottage child-care worker and one of the center's four social workers. The purpose of these meetings is to provide the parents with an opportunity to get to know each other, to discuss common problems, and to hear about their child's day-to-day experiences in the cottage. After each meeting the parents have refreshments and visit with their child.

Several of the group leaders use programed learning guides, such as "Modifying Children's Behavior"

by Robert Valett⁸ and "Living With Children" by Gerald Patterson and Elizabeth Gullion,⁹ as resource material for group discussions or individual study.

At present 85 percent of the parents who have children in placement attend these discussion groups. Four of the cottages hold their meetings in the evening; one, in the afternoon. The times were set to suit the convenience of the majority of the parents in each group. Nevertheless, a few parents cannot attend because they are working at the scheduled meeting time for their group or because they live too far from the center to attend in the evening.

Three sets of parents have refused to attend the discussion groups after their first few meetings. Although the staff has urged them to return to discuss their objections with the group members, they have not done so. These parents are, however, continuing to meet with their caseworkers.

The center pays taxi fare for a few parents who live in the inner city and are afraid to wait on the street for a bus at night.

Parental training

For many of the parents, the treatment program includes training in the handling of children. In addition to teaching child management techniques in individual therapy sessions and the discussion groups, the child-care workers invite some parents—fathers as well as mothers—to spend a few hours a week in the cottages observing the child-care staff in action. During this experience the parents not only see various kinds of techniques working successfully, but they also learn that even the experts occasionally make mistakes. This is an important observation for parents who are unable to admit a mistake to a child for fear the child will hold it against them. Parents are scheduled for this type of experience if the staff expects that the particular form of behavior that the parents are unable to handle in their child at home will occur in the cottage while the parents are there.

We sometimes encourage parents who are in a cottage for observation to interact with the children and to handle incidents involving their own child. This gives the child-care worker an excellent opportunity to offer immediate reinforcement if the parent does well, or to suggest an alternative method if the parent does poorly. However, we do not allow the parents to handle situations involving children other than their own.

The observation-participation approach was especially useful in helping Mrs. M, a divorcee, learn to



Mothers learn how to deal with their sons' disruptive behavior by observing or participating in supervised cottage activities.

manage her five children, one of whom was a resident in the center. The children, aged 8 through 16, made many demands upon her and often forced her into changing her mind about the limits she set for them.

In her therapy sessions Mrs. M and her social worker discussed many ways of being firm with her children, but Mrs. M was unable to put any of them into practice at home. Therefore, the staff decided to invite her to visit her son's cottage to observe the application of these techniques by the child-care worker in handling a group of children.

Mrs. M was reluctant to visit the cottage. However, after discussion she did agree to participate.

In her visits to the cottage she saw the success of the child-care worker's ways of dealing with the group and witnessed the worker's firmness when the children attempted through pleas and threats to change the houseparent's mind about a decision. As a result Mrs. M decided to try to handle her other children in the same fashion. Soon she was reporting increasing success.

Psychiatric evaluations

The parents are also included in the periodic evaluation of their child's progress. Each boy is the subject of an evaluation conference two or three times a year, attended by a psychiatric consultant, the treatment coordinator, a representative from the Department of Social Services, and the child-care worker, teacher, and caseworker who are assigned to the child. Sometimes the parents and child are invited to attend these conferences, not only as observers but also as participants. The experience invariably heightens their anxiety, but their nervousness does not impede the conference.

Being present at such sessions not only increases the parents' understanding of their child's needs, but also gives them a more realistic view of the staff. Any fantasy of staff omniscience they may have is dispelled as they listen to the staff discussion.

For parents who do not participate directly in the psychiatric evaluation, we often hold a "summary" conference the following week. At this conference the child's social worker, child-care worker, and teacher and occasionally the treatment coordinator discuss with the parents the child's response to the residential program. They explore the staff's understanding of the family's dynamics and future goals for the child.

Parents and teachers

The center's education department schedules two or three individualized parent-teacher conferences each year. Such meetings give the parents and their

child's teacher a chance to discuss the child's school work and his adjustment to the classroom and stimulate cooperation between the parents and the teaching staff.

We have found that these conferences are a better way of letting the parents know about the child's school progress than filling out a report card. Although the social worker in the therapy session has already discussed the child's school adjustment with the parents, they seem to feel more comfortable when presented with concrete examples of their child's schoolwork by the teacher.

The teachers often ask parents to participate in their child's educational development by reviewing some of the academic materials with him over the weekend. This practice brings the teacher and the parents into a close alliance.

We are now considering the possibility of using parents as teacher's aides in the classroom as a way of involving the parents more closely with their child's educational progress.

The center holds an open house once a year. Parents may invite relatives and friends to take a tour of the center and meet the staff, thus making it easier for them to explain their child's placement. The children are tour guides and an atmosphere of friendly informality prevails.

With a few exceptions, the boys in residence visit their homes at least every other weekend. Those who are nearing discharge visit home every weekend. A child does not visit home, however, if his parents do not have the ability to handle his behavior or if the staff has decided that a visit will not yet be good for him or his family.

Parents are often eager to talk with the child-care worker when they are returning their child to the institution after a home visit. This is a propitious time therapeutically for encouraging both parent and child to talk out their feelings about separation. However, the child-care worker often finds it impossible to talk to all the parents bringing children back and still supervise the children in the cottage. We are now trying to hire college students on a part-time basis to provide double coverage in the cottage during the several hours that the children are returning. This will free the regular child-care worker to welcome the returning children and spend some time with their parents.

In the future we plan to offer parents an opportunity to have staff members come to their home while their child is visiting. By observing the patterns of parent-child interaction in the home, the staff member

can discuss with the parents appropriate ways of dealing with the kinds of situations that arise. The staff members would also make regular followup visits to help the parents use the suggested methods.

Some problems

Occasionally parents who agree to participate in the treatment program at the time of their child's admission to the center later refuse to become involved. They cancel appointments with their social worker, fail to attend cottage group meetings, and show little interest in their child's school progress. When such signs of disinterest appear, the staff tries to find out from the parents what is happening and why. Are they having transportation problems? Do they find it difficult to relate to a particular staff member? Do they disagree with the staff on a particular point regarding their child?

If we find that the parents mistrust both the staff and program, we try to clear up the cause of the mistrust. If the difficulty cannot be overcome and the parents wish to remove their child from the center, the problem is referred to the Department of Social Services, which has custody of the child. If the department decides that returning home would be detrimental to the child, it may take the case to court. However, if the chances seem good for the child to live at home without incurring further damage, he is returned to his parents' full-time care. We have found that children make very little progress when their parents strongly object to continued residential treatment.

Sometimes we find that parents do not cooperate because they do not want to assume any responsibility for the child and do not want him returned home on a full-time basis. When this is so, we confront the parents with the fact that the center cannot assume the role of a parent and that we will recommend to the Department of Social Services that a substitute, or foster family, be found for the child.

Every child in care needs to know that there is a future for him outside the institution. We have found that when a child's parents are grossly inadequate, a foster family can provide the child with a warm, personal link with the outside community. By becoming involved with the child while he is still in residential care, a foster family offers him hope. In such instances the foster family is encouraged to participate in many aspects of the treatment program.

Our experience has shown, however, that most parents—even those who have badly neglected their chil-

dren—will respond to a respectful, hopeful attitude on the part of the staff. Parents' shortcomings have to be dealt with for the sake of the child, but a frank discussion of them rarely stands in the way of a productive parent-staff relationship when the staff also recognizes the parents' strong points and their potential for growth.

The meaning for children

What effect has the center's program of parent involvement had on the children in its care? This question cannot be definitely answered because it is difficult to single out the effects of this program from the effects of other recent changes at St. Aemilian's. For example, we have strengthened our ability to serve boys through an increase in the number of staff members and the inauguration of the day-care program.

The average length of stay of boys discharged thus far in 1971 has been 30.5 months, compared with 36 months for those discharged in 1968. Of the 57 boys discharged during the past 4 years, 39 were returned to live with their own families, nine were placed with foster families, and nine were transferred to other types of residential care. Thus there has been a gradual decrease in the average length of stay of the children in residence during the past 4 years, and the majority of the children discharged have been returned to family living—most of them with their own parents.

We believe that the increasing involvement of parents in the treatment program has played a significant role in these achievements.

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A MOTHERS' TRAINING PROGRAM—

the road to a purposeful existence

EARLADEEN D. BADGER

● Today numerous efforts are being made under various auspices to involve socially and economically disadvantaged mothers in activities to improve the quality of their children's lives. Too often, however, such activities tend just to reach those extroverts who need only a little encouragement to exercise their natural propensity to action. The apathetic among the poverty-stricken—those whose spirits seem to have succumbed to a sense of hopelessness and despair—tend to remain untouched because they have little faith in their ability to achieve. Yet these are the parents most likely to need help in raising the quality of their children's lives.

I am convinced, however, that even the most apathetic mothers can be spurred to activity in the interest of their children—with patience and conviction on the part of those who would bring this about. My conviction has been confirmed by my experience in a mothers' training project in Champaign-Urbana, Ill., carried out under the auspices of the University of Illinois from 1967 to 1969,¹ and by my subsequent experience in helping apply some of the methods developed in that project to two Parent and Child Centers.

The Champaign-Urbana project was focused on teaching socially and economically disadvantaged mothers to stimulate the cognitive development of

their 1- to 2-year-old children. A significant byproduct, however, was what it did for the mothers themselves. Over the 2-year period it changed the attitude of seemingly hopeless, helpless women to one of purposeful direction. But the change took time and steadfast persistence.

Twenty mothers, each with a child between the age of 1 and 2 years, participated in the project. They were recruited from neighborhoods of the poor through the local offices of the public aid and public health departments and by a project interviewer who canvassed acutely disadvantaged sections of the city to find families new to the city or otherwise not known to the referring agencies.

In the recruiting contacts, each mother was asked if she would be willing to attend a 2-hour meeting each week to learn how to teach her young child and to apply the methods she learned there in a daily session with the child at home. She was told she would be paid \$1.50 an hour to attend these meetings so that she could make appropriate arrangements for child care during her absence from home and that the university would provide transportation for her. She was also told she would not be paid for working with her child at home, but that toys and other materials used in the instructional program would be given to her for her baby. Finally, she was told that her child would be tested before and after the program to determine how successful she had been as a teacher.

Although the mothers interviewed readily acknowledged the importance of education to the children, they obviously did not recognize the ability to contribute to that education. On the whole they were openly skeptical about the suggestion that they could learn ways to stimulate the intellectual and language competencies of their babies at home. It took several revisits from the staff to persuade some of the mothers to give the program a try. Once they joined the group, however, not one mother dropped out before the end of the first year.

The 20 women who participated ranged in age from 19 to 56; three were grandmothers participating on behalf of a daughter's child for whom they carried major responsibility. All but four were recipients of aid to families with dependent children; the remaining four met the poverty criteria acceptable for admission to a Head Start program. All but two of the women (and children) were black. The mothers' educational level ranged from 6 to 12 years of schooling. All had at least one other child at home, the average number of children in their families being five.

Fathers were absent from all but five of these homes. Six of the women worked on a part-time basis (domestic daywork) to supplement AFDC funds; three had stable, full-time employment (a hotel maid, an aide in a nursing home, and a drugstore cashier); and one attended a beauty culture school on a full-time basis. The mothers in the families of the participating grandmothers were going to school full time.

At the beginning of the project the mean chronological age of the 20 participating children was 19 months; the range in age was from 14 to 26 months. Nine of the children were girls and 11 were boys. Their initial IQ scores ranged from 79 to 120. None of these children attended a day-care center or a preschool during or before this study.

The first year

During the first year of the project the staff work with the mothers and children took place over a period of 7 months. To encourage interaction, the 20 mothers were divided into two groups of 10 each. Weekly 2-hour meetings were scheduled for each group. Each meeting consisted of two parts: a child-centered and a mother-centered period.

In the child-centered period the mothers, with guidance and example from the staff, learned how to use educational toys and materials to stimulate their child's intellectual and language development. As the leader demonstrated teaching techniques with each new toy, she used key words that she asked each mother to use in playing with her child and to encourage the child to repeat.

In the mother-centered period the mothers, with a minimum of staff guidance, discussed with each other not only their reactions to what they were being taught but also the aspects of child-rearing, family life, and problems of living that interested them most.

Two staff members participated in these weekly meetings; one served as a group leader and the other as a recorder. They also made visits to the mothers' homes once a month, or more often when necessary, to reinforce the teaching principles introduced at the meetings and to help each mother establish a positive working relationship with her child. They evaluated the appropriateness of the children's activities and the effectiveness of the mother's teaching strategies. To foster a positive relationship between mother and child, the visiting staff member often served as a teacher-model for the mother.

The following principles of teaching were stressed both at weekly meetings and during home visits:

1. *Respect your child.* If you have a good working relationship with your child, you can be an effective teacher. A good relationship is based on mutual respect.

2. *Be positive in your approach.* Acknowledge the child's success in each new task, even when the child simply tries to do as he is instructed. Minimize mistakes, show the right way immediately, have the child attempt the task again, and praise him.

3. *Break the task into separate steps.* Teach one step at a time, starting with the simplest. Do not proceed to the next step until the child is successful with the first.

4. *Do not scold, beg, or bribe.* Your time together should be fun for both of you. If the child does not attend or try to do as instructed (and you are absolutely sure he can do what is asked), put the toys away until later.

Thus this project combined the group process with the home-tutoring methods described by Painter² and Schaefer.³

Toys were provided the mothers not only as media for stimulating the child's intellectual and language development but also as media for bringing about a positive interaction between mother and child. The toys included nests of cans and boxes, snap beads and 1-inch beads for stringing, rings in graduated sizes, a form box, and masonite shapes in various colors and sizes. These were the same kind of toys used in the Kirk tutorial study described by Painter.² In addition, the project used art materials (crayons, scissors, play dough, chalk, and slates), inexpensive books, wooden inlay puzzles with three to 12 pieces, simple lotto games, toys for unstructured play (pounding bench, busy box, and musical ball), and toys to demonstrate transfer of learning (a stack tower and interlocking cubes). The mothers were encouraged to take home the books and inlay puzzles through a "lending library" system. While the books were intended to foster language interaction between mother and child, all program toys created opportunities for verbal development.

Each family was also provided with a child's table and chair and a laundry basket for toy storage as conditioners of good work habits, order, and organization.

One home project that proved successful in stimu-

lating verbal responses from the children was making a picture book. The mother or the older children in the family cut pictures from magazines of objects the infant or toddler could recognize and pasted them in a scrapbook. Going over the pictures with the child, the mother encouraged the child to point to the objects she named or to name them himself if he could. "Reading" this book together in this manner fostered a sense of shared accomplishment between mother and child—a feeling that many of the mothers had not experienced before.

At first the work periods between mother and child often lasted no more than 10 minutes because of the shortness of the child's attention span, but within 2 to 3 months, many of the children were attending for as long as an hour.

Focus on mothers

The staff input in the mother-centered portion of the meetings was not always directly related to the mother's interest in her child. It early became evident that these mothers had had so little attention to their own needs that they had to get their feelings about themselves out in the open and clarified through discussion with one another before they could feel good enough about themselves to approach a task with any confidence of success. In other words, before they could develop a positive working rela-

tionship with their infants or toddlers, they needed to develop a greater acceptance of self.

During the early stages of the program, mothers commonly resisted change through withdrawal—helplessness was their defense. To convince them that they could alter their lives and those of their children, the group leader employed four methods:

1. *Treating the group with respect.* Throughout the project the mothers were accorded the same respect as the professional teachers. An obvious respect for their ideas and their ability to succeed helped enhance the mothers' self-image and convince them that they *could* teach.

2. *Emphasizing group responsibility.* Early in the program the leader explained that each mother could expect help in fulfilling the goals of the program through the group itself. The practice of discussing experiences of success and failure within the group contributed to the group's cohesiveness.

3. *Adopting the role of enabler.* The leader provided a model of what was appropriate in dealing with the children. In the discussion periods she reinforced pertinent aspects of the discussion, but allowed the group members to provide their own vehicle for attitude change through their interaction with each other.

4. *Honesty.* The leader at times had to say things that were not pleasant for the mothers to hear. For example, she frequently confronted the group with the inadequacy of their defenses of withdrawal and helplessness. Because of the existence of mutual respect, the members could face these issues in their discussions with each other after the leader brought them up. A direct, assertive, specific approach was thus employed rather than the traditional insight-oriented method of group therapy.

Since most of these mothers were black, the leaders presented the films "Guess Who's Coming to Dinner" and "Palmour Street" and a speaker from the black power movement to foster discussions of black pride. An interest in birth control was stimulated by a family planning counselor invited to speak before the group.

The choice of other topics was generally guided by the mothers' expression of interest. Among the subjects that occasioned much give-and-take were child discipline and the generation gap.

Occasionally, pamphlets or magazine excerpts were distributed for reading before the discussion sessions. The mothers were also taken on visits to a den-

A mother makes a game of teaching her daughter that a circle is round—a technique she learned in the mothers' program.



onstration nursery school and to the public library to obtain library cards.

Through their discussions with one another and the leader's example of respectful listening, the mothers gradually learned to respect each other's ideas. They also learned little by little to trust and communicate their own ideas and thus to gain self-confidence and self-respect.

The second year

Of the original 20 mothers, 15 continued to participate in the project during its second year—actually a term of 8 months.

Three of the five who did not return had secured full-time employment and decided they did not have time to attend the meetings, but they kept in contact with the group leader and often sought help in managing the dual roles of a working mother. Of the other two, one had died during the summer, and one, an extremely unstable 18-year-old mother of three children, had deserted her family.

In the second year, the structure of the program remained the same but the 15 mothers met as a single group with one staff member only for most of the term. During the last 2 months the staff member was aided by a group-leader trainee.

Children's activities. Many of the child-centered activities were aimed at extending the gains made in the first year. Form perception, encouraged the first year with the use of a form box and the masonite shapes, was reinforced the second year with the use of masonite templates. The 1-inch beads were replaced by half-inch beads, and all the children learned to string them. Matching skills acquired in the first year through lotto games played with objects were enhanced by classification activities the second year.

Using margarine containers, the children sorted concrete objects and eventually 1-inch cardboard disks with pictured objects. Most of the children learned to recognize and name three shapes (circle, square, and triangle) and to distinguish big-, little-, and middle-sized shapes.

The children learned to sort objects or pictures into two to six categories, to distinguish among the alphabet letters A through F, and to arrange colored rods of five lengths in sequence. Color and number concepts were emphasized in all these activities, as were the vocabularies of sequence and dimension. The five oldest children knew the seven basic colors at the end of the second year, and could count concrete objects

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up to five and reverse the count as objects were removed.

All the children regularly used the art materials and pasted their own products—a snowman, geometric shapes, collages—into a scrapbook. Puzzles with as many as 20 pieces were added to the lending library as were toys, pictures, puppets, beaded number cards, pegboards, blocks, and more books. By the end of the term some of the older children could put the 20-piece puzzles together correctly.

Each child received a set of three books from which mother and child were given assignments to “read” together in a manner demonstrated by the teacher.

Spatial relationships connoted by prepositions were introduced to the children by manipulating objects on a table and using a picture book designed for this purpose. Words such as “first,” “next,” and “last” were also stressed. The children used rubber and plastic dolls and toy animals and autos in these exercises.

The children learned about direction as they drew lines on paper and copied patterns drawn by their mothers. Through regular practice in making circles and horizontal and vertical lines, several of the older children learned to draw a stick figure, correctly placing hair, eyes, ears, mouth, and fingers. Some of them became adept at following a multicurved line with a crayon. All of the children enjoyed cutting and coloring activities, and several of the 3-year-olds were successful in continuous cutting action following simple outlines with their scissors.

All these activities were encouraged by the mothers in their homes after they learned how to do so in the practice and observation sessions at their weekly meetings. In addition they again kept a scrapbook for the child, but this time the child cut the pictures out and pasted them in himself or colored pictures put there by his mother.

During her home visits the staff member observed a general improvement in the working relationship between mother and child, which was regularly rein-

forced by the mother's praise of the child's progress. She also noted the following improvements in all the children, though in varying degrees:

- An increased attention span on the part of the child.
- Greater persistence and an increased frustration tolerance in solving problems.
- A logical order in thinking with an ability to transfer a lesson learned from familiar to new material.

The mothers were obviously delighted with the skills and abilities they had helped their children develop.

The mothers' growth

With encouragement from the staff the mother-centered portions of the second year's meetings increasingly emphasized ways of becoming involved in community affairs. Some of the mothers began to take part in community activities and to share their views and experiences in this regard in the mothers' group meetings. Their enthusiasm emboldened others to become more assertive.

The mothers revealed their increased self-confidence by—

- *Sharing staff responsibilities.* One mother served as notetaker for all the meetings; four mothers were trained as home visitors and ably performed in this capacity; five mothers presented talks at regular meetings and moderated the discussions that followed.

- *Initiating plans.* The mothers planned and presented a demonstration of what they had learned for eight visitors from the Peabody College for Teachers. They also planned and participated in making a video-tape focused on solutions to community and family problems. In addition, four mothers participated in a taped discussion on family planning. Another mother arranged for a speaker to give the group a talk on black history.

- *Volunteering suggestions.* Mothers frequently offered suggestions and comments during the instructional sessions regarding the teaching principles presented by the staff leader. Such spontaneous contributions had not occurred the first year. The mothers were also generally more receptive to guest speakers than they had been the first year.

The most frequent type of community activity engaged in by the mothers was in connection with preschool education. Perhaps the most outstanding example of self-help and purposeful direction was provided by a mother of seven children. She attended school for 3 hours a night, 4 nights a week, for a period of 3 months to prepare for the high school equivalency examination so that she could get a job as a teacher's aide and "get off welfare." Other mothers became involved in a Head Start program: one mother was hired as an assistant teacher in a Head Start center, two mothers presented talks about the mothers' training program to Head Start parents groups, another mother attended a 3-day Head Start inservice training program in Chicago, and four mothers helped recruit children for enrollment in the Head Start summer program.

Some mothers also became involved in other type of community affairs. One presented a talk at a PTA council meeting in which she suggested that all mothers should have an opportunity to participate in programs to teach them to help their children prepare for success in school. Another mother helped form a new mothers' group at a local public school. One mother obtained a job as a home visitor for the local Planned Parenthood Clinic. Five mothers took advantage of a university-sponsored trip to Chicago to hear a speech by Rev. Jesse Jackson of Operation Breadbasket and to learn more about self-help programs in large metropolitan areas. When the local Economic Opportunity Council called a meeting to discuss the possibility of establishing a parent and child center in the community, 12 of the 15 mothers in the group attended; they were the only persons there who were indigenous to the neighborhood.

Some implications

Toward the end of the project, the children in the program were tested on standardized measures and their scores compared to those of children in a matched control group and also with a control group composed of their siblings. The scores of the experimental group were significantly higher than the scores of either of the control groups.¹

However, if the merits of this program are considered only in terms of its impact on the child-participants, then its real significance is overlooked. A program for the disadvantaged that directs itself to the education of parents hits the real target. Behavioral characteristics related to a child's success in school and society are learned at home and exter-

from parent to child. If parents feel a sense of defeat and hopelessness, so will their children; but if they exude a feeling of self-confidence, this will be transmitted to their children.

Attendance records are useful in assessing the impact of the 2-year mothers' training program. The average attendance of the 20 mothers during the first year and of the 15 mothers the second year was 80 percent. Such a highly stable attendance record is impressive for mothers supposedly of the "culture of poverty" who, according to sociological and anthropological studies,⁴⁻⁷ are trapped in a disabling, self-perpetuating cycle of purposeless existence.

Attendance records, however, do not reveal the intensity of the mothers' commitment. The important criterion of success is the relationship each mother established with her child.

Thomas Gladwin has expressed doubts about the inevitable perpetuation of the culture of poverty. He has suggested that any program for the poor must first convince the poor that they *can* control their destiny and that they *do* have a future. The program may not bring these conditions into existence, but it must convince the poor that self-determination is possible.⁸ In this regard, an important aspect of the mothers' training program was the sincere and frequently expressed belief that socially disadvantaged mothers *can* change their lives and that they *want* to. Equally important was the conviction that educationally disadvantaged mothers can become effective teachers of their infants.

This project demonstrated the importance of structure in planning and well defined goals in encouraging the sense of self-realization and self-help prerequisite to confident self-direction. It also demonstrated the importance of *time* in effecting attitude change.

Change in the mothers' attitudes began when they discovered they were effective teachers of their infants and toddlers. As they learned to control and order their lives in one area, they extended control to other areas. One manifestation of their new sense of self-determination was a changed attitude toward birth control. In this highly fecund group only one mother became pregnant during the 2-year period.

Time is an important ingredient in any program that hopes to effect attitude change coupled with social action. In the first year of this program numerous attempts on the part of the leader to encourage community involvement met with discouraging results. These mothers had spent the greater part of their lives "tuned out" to the world around them.

For them the goal of existence was to survive. Only very slowly did they learn how to listen and to speak in a group. The various kinds of community activities in which members of the group engaged during the second year of the project, compared with the resistance and defeatism encountered during the first year, clearly indicates that *time* is a requisite in the evolutionary process of a group approach.

The failure of many program sponsors to consider time as a variable when determining expectations for parents may explain why so many programs rarely yield more than short-term benefits. Parental involvement will not be won unless program leaders demonstrate a high level of commitment and perseverance.

Defeatism, alienation, and a sense of powerlessness in parents can be replaced with a sense of purpose—a purpose which may begin with a mother's interest and concern for her child's future and may be extended to efforts to change the institutions in society that maintain the status quo of the poor.

In recent months I have been engaged in the training of nonprofessional workers in a Parent and Child Center in Mount Carmel, Ill., to teach parents to teach their children, using the principles described here. The experience has shown that the required level of commitment can be found and nurtured in such workers, and that they in turn can transmit their enthusiasm to the parents with whom they work. Perhaps in this direction there lies a possibility of starting a chain reaction among the poor of any color to take up the same challenge Nathan Wright, Jr., has addressed to the black: "We have not become what we shall become."⁹

⁴ Karnes, M. B.; Teska, J. A.; Hodgins, A. S.; Badger, E. D.: Educational intervention at home by mothers of disadvantaged infants. *Child Development*, December 1970.

⁵ Painter, Genevieve B.: Infant education. Dimensions Publishing Co., San Rafael, Calif. 1968.

⁶ Schaefer, Earl S.: A home tutoring program. *Children*, March-April 1969.

⁷ Rainwater, Lee: And the poor get children. Quadrangle Books, Chicago, Ill. 1960.

⁸ Moynihan, Daniel P.: The Negro family: the case for national action. U.S. Department of Labor, Washington, D.C. 1965.

⁹ Frazier, E. Franklin: The Negro family in the United States. University of Chicago Press, Chicago, Ill. 1966.

⁷ Lewis, Oscar: La Vida: A Puerto Rican family in the culture of poverty—San Juan and New York. Random House, New York, N.Y. 1968.

⁸ Gladwin, Thomas: The anthropologist's view of poverty. *The Social Welfare Forum*, 1961. Columbia University Press, New York, N.Y. 1961.

⁹ Wright, Nathan, Jr.: Black power and urban unrest. Hawthorne Books, Inc., New York, N.Y. 1967.

A PLAY CENTER FOR DEVELOPMENTALLY HANDICAPPED INFANTS

FLORENCE DIAMONI

● The time to intervene in developmental retardation is in infancy. Of this there is no longer any question. But how? One way has been initiated at Villa Esperanza, a nonprofit voluntary school in Pasadena, Calif. Here a tiny cottage—known as the Edward Levy Infant Center (Elic) in honor of a much loved “granduncle” volunteer—has been converted into a playschool for developmentally handicapped infants from 3 months to 2½ years of age.

The Elic program, now in its fourth year, is making converts of pediatricians who at first were skeptical. The goals of the Elic program are (1) to make possible a full and meaningful life for developmentally retarded children and (2) to help establish as early as possible normal living patterns for both the children and their parents.

Infants are considered developmentally retarded when they are functioning sufficiently below age expectations to cause professional concern about their delayed emotional, social, or cognitive progress. Major causes of retardation among our infants are birth injury, encephalitis, infantile autism, blindness, deprivation, and congenital factors such as rubella and Down's syndrome.

The retarded infant is twice disadvantaged. First, although he needs more assistance in progressing through the stages of development than the non-handicapped infant, he receives less and that less too late. Second, like all babies, his emotional health depends upon the good emotional health of his parents, but because he is a handicapped child, his

parents suffer fear, anguish, bewilderment, and to often shame. Parents who have just realized that they have a handicapped child need emotional support not only from their families (and too often that is denied them) but also from the community.

In 1968 as chairman of Villa Esperanza's education committee, I undertook the task of developing an infant program that would serve the developmentally retarded. Perhaps because of my long association with nursery schools, I was propelled toward designing an ideal nursery school with a curriculum appropriate for children in the creeping and crawling stages. There was no model for us to follow. There was only the conviction on the part of the staff and Villa's director, Elene Chaffee, that we would find a way.

We started with five fundamental principles:

1. All infants, handicapped and nonhandicapped are more alike than different.
2. The retarded are not equally handicapped in all areas of their development. They may even be advanced in some areas.
3. Each individual, whether parent, baby, or other, has a life that is to be respected. The preciousness of life is not to be measured in IQ points.
4. While all children are more alike than different, each is also different with his own patterns of development, satisfactions, and needs.



have taken a lesson from the Japanese. We and the babies live on the floor.

All adults doff their shoes upon entering the building. Instead of tatami on the floors, we have put in heavily padded wall-to-wall golden yellow carpeting throughout the building, except in the second playroom. Here we have vinyl—better for wheeltoys, wiping up food spills, and of course, for early toddling.

We opened with six babies—all we want at one time in our small cottage. My feelings on that first day (as I drove to the infant center) were a mixture of hope and anxiety. It was raining heavily, and I wondered if the parents would even come out. They did. They tenderly placed their little ones on our carpeted floor and stood back. We turned on soft music. The babies looked one another over, and the miracle happened. They smiled. We knew that Elic, the infant play-school, was born. Since then we have served 42 families.

In all of these cases we have been able to make a significant contribution. However, there is also an element of failure in about 10 percent of them. For example, there is the mother who never gave up her search for a complete magical cure of her son, severely handicapped by congenital rubella. Another “martyred” mother abruptly withdrew her neurologically handicapped daughter at the first dramatic signs of emotional improvement.

With a few exceptions, the parents have expressed great enthusiasm for the program. We have not rejected any applicants because of inability to meet our fees, thanks to our liberal scholarship program.

At first the children came three times a week from 9 to 11:30 a.m. But it is very hard to turn away babies and parents in need of help. So, in order to expand our services, we are now open 5 days a week. This schedule provides a total of 30 child-days each week for our infants. By assigning the 30 child-days in a variety of individual schedules, we attempt to get optimal grouping of infants according to their needs and interactions.

Agency cooperation

New parents learn of Elic through the Child Development Clinic, the Department of Public Social Services, the Regional Center for the Mentally Handicapped, Field Service for the Blind, our own parents, and increasingly from pediatricians who have seen the benefits to infants and parents.

The majority of the infants are evaluated by the Child Development Clinic in Pasadena, either before

5. Teachers and parents must avoid the twin evils of overstimulation and inaction.

A successful infant program can take many forms. We like the one we are evolving. Elic is an infant play-school where planned programs are thoroughly mixed with love and laughter.

The setting

Our cottage has two adjoining playrooms, an observation room, a diaper and potty room, and a minuscule reception room. In deciding that babies do not need cribs, playpens, or much other furniture, we

Every child needs to love and be loved . . . to achieve . . . to play and be played with

or immediately after they enter Elic. Others have been diagnosed at Children's Hospital of Los Angeles, USC Medical Center, the Neuropsychiatric Institute of UCLA, or by their own pediatricians. We participate in these evaluations and also make our own diagnostic studies.

We see to it that every child has the benefit of available services of agencies in the city and county. Our school nurse and our social worker help parents follow through on all recommendations. Excellent working relationships exist between our staff and the staffs of the agencies. For example, when physiotherapy is provided by the Crippled Children's Services, the head teacher is invited to observe the methods so that she can incorporate them into the child's program; when fieldworkers from other agencies want to get a fuller understanding of children they are also serving, they come to Elic.

The teaching staff consists of a head teacher, an assistant teacher, and a speech consultant who spends an hour each morning with the infants. In addition, the school nurse visits the cottage daily and the social worker and I are often present. Thus we are prepared to move swiftly to protect the infants if it should be necessary to evacuate the building or call upon an extra adult for a special service.

An infant teacher needs to be a warm, imaginative, stable, tranquil person with a zest for life. We are fortunate in our staff. Elic's head teacher is a well trained and experienced nursery school teacher with a solid foundation in infant and child development. Her assistant is enrolled in career training.

Curriculum

The child's needs determine the curriculum. We start from the premise that every child has the need to love and be loved; to transmit and receive communications, to build, to explore, to achieve, and to play and be played with. Parents and teachers of nonhandicapped children usually have little difficulty

in recognizing these needs. They have only to listen and watch.

But often the handicapped child cannot give the appropriate signals. Further, there tends to be an imbalance among his abilities.

For example, Harold reads facial expression remarkably well. He is fascinated by pictures and shapes, but his legs are weak and he is limited in his explorations. He is also lagging behind his age group in his ability to communicate. These conditions are very frustrating to him.

If we and his parents followed the public school system of waiting until he was 6 or even 8 years old before providing him with learning experiences, the satisfactions he now has in fitting shapes and forms together, reading picture books, and building with blocks would have been denied him. He would have had no experiences of success, no joy in achievement. He would be withdrawn and apathetic. His abilities would have atrophied from lack of use.

It is our task to see that we do not allow our children to be reduced to the level of their most retarded function, but to help them to achieve in each area of their development whatever level they are comfortably able to reach. It is just as important that we do not force Harold to walk upon legs that are not ready, thereby subjecting him to unfortunate experiences of failure and frustration as it is that we give him opportunities to enjoy the triumphs of building towers and bridges.

Handicaps are not necessarily physical. We have one baby, now in a foster home, whom we diagnosed as suffering from hospitalism. We are teaching the child to smile. We discovered that he likes sudden strong motion. We cuddle him, jiggle him, toss him in the air, and he crows. He is making progress. Now his formerly stiff body curves into the contour of his teacher's. His cheeks are getting rosy, his eyes less empty, hair is growing on the back of his head, and the bed sores are disappearing.

Our first blind child came to Elic when he was a year old. We wondered, as he started to walk, if a

he toys had to be removed from the floor so that he would not fall. Would all the furniture have to remain in exactly the same spot so that he could navigate better? We tried to clear his path, but somehow other babies were always getting in the way and somehow toys were strewn across the floor. We knew that our floor was cushioned and that nothing had sharp corners, so we relaxed and watched. He learned to walk, learned to avoid hazards and was very proud of himself. Visitors watching him move around could not believe that he was totally blind. When he came to us, he was retarded beyond the expected level of a blind child—content to sit and do nothing. Now he is no longer retarded.

Play is essential

As I have already mentioned, we incorporate into each child's program techniques and methods proposed by physiotherapists. We also use planned programming on occasion. But we include such techniques as part of fun time, for we believe that play is essential to a young child. Play is the way a kitten, a

puppy, a baby chimp, or a human baby gains mastery and avoids anxiety. Anxiety comes with pressure and standards to be met. Whether or not pressured learning has a value for the child of school age may be debated by others. For the infant and toddler, it is assuredly detrimental.

We devote much of our program to developing speech. Our speech therapist reinforces speech patterns; stimulates, sings to, and rocks the babies; plays games with them and delights them by whispering secrets into their ears. Sometimes she lies flat on her stomach in front of a long horizontal mirror and talks to them through the mirror. They watch her lips and try to imitate her. It was a great day when Harold stopped babbling and started to use jargon. We knew that soon he would be talking.

Serendipity has played a big role in our selection of toys and equipment. The mirror hung on the wall near the floor is an example. It was installed for the usual reasons: to promote individuation and to assist in the teaching of speech. The mirror delights the children. They pat themselves and kiss themselves

These developmentally handicapped infants are getting acquainted in front of a large wall mirror hung at toddler-eye level.



on it while they learn about themselves. The mirror has also proven to be a valuable method of communicating with disturbed children. A new face may be threatening to any young infant; eye contact may be even more threatening, especially to an autistic child. The mirror allows the child to gain visual distance from the teacher while she has the advantage of still being in close physical contact with him.

We consider the rocking chair a "must" in our activities. We have also found beach and swimming pool items useful. Our babies have fun exercising on a partially inflated balloon, about 2 feet in diameter. Tumble tubs, intended for swimming pools, work very well on a soft carpet—provided with a pillow, they serve as cradles in which an infant may be rocked. They are also round-bottom boats in which four may sit and socialize as they play rub-a-dub-dub. Or, as Larry, a 2-year-old microcephalic, has shown us, they can be a most challenging saucer in which an acrobat can stand and successfully maintain balance.

Rocking horses, kiddie cars, a set of shallow steps, a gentle slide, a sturdy walker, feeding tables, and cube-table-chairs are among the larger items we use. A good record player and a drum are other musts, because music and rhythm are meaningful to infants and toddlers. Then there are the many small items for the infants to feel, manipulate, mouth, rattle, ring, and build with. We select simple picture books. Toys are on open shelves, accessible to the infants.

We have a relaxed attitude about toilet training and we also help parents take a casual attitude. Modern disposable diapers and plastic bags have simplified the problems of sanitation and changes. When the child can sit with ease and can toddle, we introduce him to the potty chair, but we make no issue of it. We measure the success of this approach by what happens when the toddler graduates from the infant center and enters the nursery group. There he learns toilet training quickly and proudly.

Parents

We are as much concerned about the parents as about their infants. What do parents need? They need to know that they are important as people—not because they are Harold's or Tillie's parents. They need to be able to let their children go forth. They need to know that they are not their child's only resource, that others care and are willing to help. They need to lead normal lives.

In the beginning we planned a didactic program, with scheduled parent participation, parent observa-

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tions, and group meetings centered about the infant needs or the parents' own feelings. As we watched the parents and gained greater security in our philosophy—the need to lead normal lives—we have developed a different, less structured approach to the program for parents. We do hold scheduled evening meetings, however, so that fathers can attend.

When an infant first enters the center, we ask the mother to stay with her child. She gradually moves from the playroom to the observation room with a one-way-vision mirror. When the infant feels secure in the center, the mother is free to leave his world for the morning. She may get her hair set, take a class (parents help one another arrange time), or play hookey in any way she likes. Of course, she may observe her infant whenever she wishes.

Friendships develop among parents. From concern about their own infants, they share concern with other parents, and they delight in the progress of all the children.

The staff members are the catalysts for, not the organizers of, parent involvement. When the parents have special problems, the staff is always willing to find time for an informal conference. Often a mother will discuss a problem with me when I am in the observation room. Sometimes the informal conference will last only 5 minutes, sometimes an hour. When we realize that a parent is troubled, we initiate discussion.

At Ellic we serve as a resource by providing a learning situation. But we do not teach. When freed from anxieties, most parents do a good job in helping the handicapped child develop. Our greatest satisfaction is watching the lines of anxiety disappear from parents' faces, and the tight muscles in their necks and shoulders relax.

Soon, we hope, there will be other play centers for developmentally handicapped infants in Southern California. Consultants from three schools have been studying our program with the intention of establishing similar programs.

THIRTY YEARS of INNOVATION in FOSTER CARE

MYRA TIEDER



● The heart of the problem of caring for children away from their own homes has always been the slowness with which knowledge has been accrued and then applied, and a lack of resources to implement the creative ideas of the people dedicated to serving such children. In presenting here a retrospective view of my own efforts in behalf of the child placed away from home—not by choice, but by failures somewhere in his own development, in his family, or in society itself—I will attempt to distill for the reader the elements that keep professional and paraprofessional people in this often heartbreaking work of foster care.

My entry into the field was at the beginning of the great depression of the 1930's. While the need for training then was as great as it is today, the orientation of new workers was almost nil in comparison with the inservice training and support now generally provided. I began as an untrained "volunteer" with minimum qualifications. One can only wonder how the present "innovative" programs using nonprofessionals in social services will be viewed in the future. To some, such programs may well look like as escape from rigid professional standards. To others, they may seem to be shortchanging the consumer by failing to give him the best help available because he cannot always pay for it.

My volunteer status lasted about 2 years, thanks to a tolerant—if hungry—family, the fortuitousness of nothing else showing up, and the never-lost sense of the rightness of this field for me.

Aftercare

Despite a lack of qualifications for my first job, my youth and vitality entitled me to full caseload. There were minimum safeguards for me and my clients, and supervision on a "how-to" basis only. I plunged into the situation with goodwill and the assurance that workers knew better than clients what their needs were and how to get them met. Helping the child to come home and stay home was the object of my efforts. This was known as aftercare.

I would say that there has been less change in aftercare than in any other aspect of work with children. The modifications in family life that were expected then were modest. The drive for reunion was as strong then as now, and the professional

views of the rightness of it—except in some rare instances—were realistic.

The fears then were that the child, after living better than his family socially and economically, might find the return home difficult. The children served by the agency were Jewish children of immigrant families, and the institutional care they received enriched them far beyond what most of their families could do for them. The Americanization process taking place in these children created vast differences between them and their parents. The niceties stressed in institutional living were not valued in the home.

The worker needed then, as now, the kind of perspective that could reach out to her divergent clientele. If she came to social work convinced that she knew the answers, the hardness of these parents, who had faced dislocation, emigration, poverty, and family breakdown, soon taught her what schools of social work have since worked hard to demonstrate: the uniqueness of the individual and his strength, with help, for finding his own solution.

Did we learn any lessons in those days that have meaning for today? The fear of broadening the gulf between people—generational, cultural, and economic—is real today. Perhaps it must always be left with the consumers of our services to take only what is tolerable to them, rejecting what they find intolerable as a body rejects a foreign organ. Or perhaps, like the medical scientists, social workers can develop the skill to avert such rejection.

When I remember the children who, upon returning to their own homes after placement in foster homes, were able to live with a greater degree of comfort and gratification than they had previously, I can only feel that we must have been doing something right.

I think, for example, of a 10-year-old girl who was brought in for placement after having slept for months on the subways with her homeless and helpless parents. During a prolonged stay in an institution, this young client put so much pressure on the

social worker to be returned to her family that the worker became the family's advocate, helping them obtain public assistance, an apartment, and furniture. The girl made it clear that she realized that in knowing how and perhaps intellect, there would be a role reversal in her family—she would be the one to have to take responsibility for cleanliness, school attendance, health, and other needs.

While this girl's precocious assumption of adult responsibility might be cause for concern, one can only applaud her strength in knowing what she needed and in getting herself heard, and her recognition that there were values for her in her parents that she could now enjoy.

The factor of evolution in parent-child relationships is most assuredly one that social workers must learn to look at critically.

Family placement

At that point in time, the mid-1940's, my colleagues and I seemed very sure of the *modus operandi*. Our agency's policies recognized that it was important for the child to know about his status and that was important for all concerned to acknowledge the role of the agency in the child's life. However, the "how" of these principles was seldom varied from child to child. Thus the social worker dealt with a child in a long term foster family in the same way she dealt with a child who remained in a foster family only a few weeks, ignoring the developing relationships with the foster parents. The leading actors in this real-life drama—the child and the foster parents—grew increasingly hostile to the social worker with the passage of time. The now accepted practice of adjusting the role of the social worker according to the needs of foster child and parent is a welcome and valid change.

This was a period when the mother was the beginning and end-all of the foster family, although somewhere in the home study the foster father had to be seen. Unfortunately, unless the man was a most unusual person in his determination to be counted, he was rarely consulted thereafter, except after a crisis arose. Today many agencies insist that the father be involved in foster care on a consistent basis.

Gradually a group of social workers to which I belonged began to develop our own theoretical concepts based on our experiences in foster family care. After much discussion, we pulled together our ideas by writing an article. It was almost rejected for publication because we suggested that for the young child

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placement away from his family is an experience close to dying.

Knowing what we now know about a child's mourning when separated from his parents and his need to deny and bargain before he comes to terms with the inevitable, I still feel uncertain about how we can help children move from their own homes into foster placement.

I have watched a foreign-born foster mother, whose life has been burdened with many experiences of separation, use an intuitive approach to grieving children to allow them to practice denial of a need. She was for placating and covering up for a while, in contrast to the worker who stood firmly for helping the child face reality immediately.

I think we were full of such uncertain certainties out of our own need to deny. We cut the child off from his earlier relationships because he could not be "torn apart" or "live in two places." But, inconsistently, we established arbitrary rules about visits between parents and children. Moreover, although the value of the new foster home was attested by our agency's stamp of approval, we often attempted to impose our own cultural patterns on it rather than working within the differences.

It would be naïve to feel that our ideas made any inroads in many of the foster families. Rather, I suspect, the mother in the home, being sure of herself, listened well and practiced what she would have preached if she had been less modest.

To illustrate: Once, when as a supervisor I found evidence of some authoritarianism in a worker's dealings with an experienced foster mother, I explained to the worker the need to take a more delicate approach. She followed my advice. On her next visit the foster mother, quickly sensing the change, wisely said, "This is much better. I hope your new supervisor didn't give you too much trouble."

In those days we began to differentiate foster homes by function—temporary or long-term—and perhaps this was the beginning of today's movement toward group homes, agency homes, specialized homes, emergency homes, and so forth. The differential use of a variety of resources will demand a continuing development of special skills.

Somewhat belatedly I would like to acknowledge the contribution of the foster mothers of the depression period. We searched out their motivations, especially suspecting economic need, for we did pay for care. One of the more courageous of my foster mothers was always protesting our board rate. I could not imagine why since she was receiving \$25 a

month—a higher allowance than most social agencies were paying for total care of a 10-year-old boy.

On a visit to her home during the foster child's lunch hour one February day, I was amazed to see him eating strawberries and cream. Noticing my raised eyebrows, Mrs. G quieted any impulse I might have had to comment by saying, "When my heart wants strawberries and cream in February, his stomach gets it."

Vicissitudes and rewards

One of the vicissitudes of being a woman placement worker is facing a view of your own life through the eyes of experienced foster parents. Without any knowledge of Erikson or even Shakespeare, such parents have developed a concept about the stages of development. Thus, although an unmarried worker is fortyish, she is still a girl—a person who has not developed strength through the battle of the sexes. After marriage, the worker's childlessness is the differentiating factor; how could she really *feel* without having conceived, carried, and borne a child? And after becoming a mother, she must weather the criticism of returning to work and leaving her child at home. Then the worker faces another paradox—the foster parents express the hope that someday her ship will come in and she will no longer have to work.

At the time I found these criticisms painful, so I failed to get the message. These people saw in their mothering role the fullest fruition for themselves, not to be compared with outside work, greater pay, and other temptations. Were we ever to develop an evaluative form to scan for such a quality, our current plight in inadequate foster home supply might be alleviated.

Despite the unwieldy size of our caseloads, the placement worker, then as now, had many happy experiences. I remember a letter written by a refugee child to her parents urging them not to worry about her. Here in the United States, she said, she had a social worker whose whole job was to worry about their daughter.

Our unsophisticated efforts to cope with a need in which there were not any tried and tested methods were as innovative in their day as are those in the current rash of new practices and programs. Perhaps we should recognize that changes in practices are most likely to succeed if they stem from necessity and from determination to serve the client effectively.

When I moved from foster family placement into

institutional work, I met with rigidities about practice that kept changes from coming at more than a turtle-like pace. During this period the use of foster homes was skimming off the "easy to place" child, leaving the institutions to deal with the exceptional (or disturbed) child. Because of the existence of institutional facilities, a decrease in caseload that would be welcomed in other aspects of social work represented a problem. Practices were more related to management than to treatment. Smooth operations were an end in and of themselves.

However, there was a built-in asset in the tremendous tolerance for children among staff members of diverse backgrounds and training. Also the exposure of child and parents to the problems of other children and parents presented therapeutic opportunities we were perhaps too slow to recognize. Even now there is a reluctance to use the incidences of daily living to therapeutic advantage, or to recognize that if we listen to children we can often learn truths that we would resist learning on our own.

A common change in voluntary institutions in the 1950's was a move toward racial integration as a result of the pressure of the times and conscience.

The children's capacity to accept difference was far in advance of that of the adults. For example, I remember one of the first black children served by my Jewish agency—John, on his bike, with his St. Christopher's medal shining in the sun—joyously bebopping words learned from the tapes of a nonreading friend's Bar Mitzvah preparation: "Beroke my toy adenoid" (Barukh Attah Adonai—Blessed art Thou, O Lord). Thus, John made a kind of mincemeat of stereotypes.

How agencies involved in change can utilize their clients' capacities in bringing about change is an area for further exploration.

The recognition of the paraprofessionals, the development of open-ended career ladders, the child-care worker's striving for professionalism—all of these movements have been both the bugaboo and the hope of child-caring institutions. We need to be even more innovative in providing job gratification to prevent the staff turnover so detrimental to children. Learning to screen applicants more effectively for child-care positions, providing promotional opportunities, using staff members in different ways, improving salaries, and providing greater status for persons in child-caring positions might be ways of attracting and retaining good people to work on the staffs of institutions for children.

The shared experiences in institutional living

might be used more fully in developing the professional potential of the staff. The group method can also be employed in helping the children's parents. Parents have occasionally shown their readiness for this by protesting certain practices—regarding visiting allowances and the like—through group action. How much better if the staff had initiated the practice of working on such problems with the parents!

What now?

What is the value of such retrospection? It has strengthened my long-standing conviction that child welfare agencies have the capacity to work toward solution of problems and find answers to service needs, shortages of staff and finances notwithstanding. What is required is concentration on making services available in many different ways through creativity, inventiveness, and in some cases daring.

For example, take the shortage of foster parents. Are there different patterns of service that could be developed to make child care a more acceptable vocation? Or, what about preventing the separation of mothers and children in the first place? Could group residences be developed for unwed mothers and their children where efforts would be made to strengthen the mothers' ties to their babies? Or what about paying for services within families?

Ways must be found to husband all the strength of family living through inundation with unique and stabilizing efforts before placement becomes necessary. Placement must be seen for what it is, a radical treatment method. Our clients have so often told us that if they had had certain kinds of help immediately at certain times in their crisis-filled lives, the family breakup might not have occurred.

In an urge to innovate, however, we can get so "hung up" on newness that we can fail to benefit from the trials and errors of the past. We must be careful to avoid creating new areas of difficulty. How do we correlate the new situations we are creating—for example, transracial adoptions and one-parent foster homes—with our knowledge of the developmental needs of children? We must be cautious about overselling our newest ideas and recognize that we do not have the answers. Perhaps what is needed is a "think tank" to work on the unsolved problems of child care in a changing, and often disorganizing, society.

To young social workers entering the field, I would say, yes—innovate, experiment, challenge the establishment. But do this with the foresight not available to many of your predecessors, lest you compound our errors.

OCCUPATIONAL THERAPY and SPECIAL EDUCATION

MARLYS MARIE MITCHELL

● In recent years occupational therapists have quickened their move out from the familiar medical settings into educational facilities for physically or mentally handicapped children—long the domain of special educators. In many instances, such moves have resulted in a productive partnership of the two disciplines, each with its own techniques and specific objectives, but with the common goal of helping the child surmount his handicaps. Such an interdisciplinary partnership can only develop, however, if program planners have an appreciation of the potential of interdisciplinary teamwork and if the representative of each discipline has a clear understanding of the distinctiveness of his own and the other's role and of the way these roles can be dovetailed to strengthen the service to the child. Therefore, a review of the functions and relationships of these two professions seems pertinent at this time.

The role of the occupational therapist in work with handicapped children has been evolving over a number of years as the profession has grown and as the contribution it can make to the diagnosis and treatment of various kinds of handicaps has become recognized by members of other professions. In this evolution there has been a gradual broadening of the scope of interest from purely physical handicaps to a broad range of health problems^{1,2}, including, for example, problems with obscure or complicated causes, such as mental retardation and perceptual

motor dysfunction. A recent study has shown that among the advanced degrees earned by occupational therapists many are in special education.³

Occupational therapists who work with the mentally retarded have recently formed a Mental Retardation Special Interest Group within the American Occupational Therapy Association.⁴ This group aims to stimulate an interest in mental retardation among other occupational therapists, to coordinate services, to exchange information with national organizations concerned with mental retardation and to share the profession's special body of knowledge with other professions.

This increasing range of interest and activities is reflected in the definition of occupational therapy adopted in 1968 by the American Occupational Therapy Association: "Occupational therapy is the art and science of directing man's response to selected activity to promote and maintain health, to prevent disability, to evaluate behavior and to treat or train patients with physical or psychosocial dysfunction."⁵

Special education

Special education is concerned with the instruction of children who are exceptional in at least one of many ways—that is, children who are different from the hard-to-define "normal" child in one or more educationally significant areas.⁶ That difference may be physical, mental, or emotional-social in character; that it is a difference may be determined by statistical, empirical evidence supplemented by subjective information. The significance of the difference depends on whether or not it is a weakness and if so, the degree of disability it causes the child in keeping up with his peers.

The goals and objectives of instructing exceptional children are similar to those of instructing normal children. Broadly, they are the development of civic responsibility, a capacity for human relationships,

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self-realization, and economic efficiency. More specific objectives taken together tend to emphasize occupational adequacy, social competence, and personal adequacy. The most immediate objective, however, is to develop the child's ability to process information, for without this skill learning cannot take place.

Whether one speaks of development of associational patterns, programing and task analysis, conditioning, interaction analysis, or any of a multitude of educational concepts, the basic aim of special education is to help the child or adult develop the skills, knowledge, and ability to function in, and, if possible, contribute to our society and become as self-sufficient as possible—in other words to overcome the deficiency that has made him different. And here is where the objectives and goals of occupational therapy and special education meet.

Parallel programs

Both professions are concerned with treating and training the handicapped person. Both attempt to evaluate behavior, whether it is muscular, social, or mental. Both are concerned with the physical, emotional, social, and mental aspects of a child or adult. Both are concerned with intellectual factors and their implications for behavior and social functioning. Their techniques differ, but their programs are parallel.

Occupational therapy is provided in psychiatric settings, facilities for physical habilitation, medical clinics, vocational or prevocational schools, and special classes and, for homebound children, in the child's home. Special education takes place in similar settings through classes for the emotionally disturbed or socially maladjusted, for the physically handicapped, for the hospitalized, for children in special schools or special classes in public schools, in prevocational programs, in sheltered workshops and in individual classes for the homebound. Despite some overlap, what results is mutually supporting complementary services rather than any real duplication of services. In the end the child or the patient—the *raison d'être* of the program—benefits.

For example, in working with physically handicapped children, occupational therapists may build the splints or other adaptive equipment that enables the child to hold a pencil. Special education teachers are not usually taught to do this. Once the child can hold the pencil, special education teachers teach the child to write or multiply. Occupational therapists are not usually trained to do this. Thus the occupa-



tional therapist and the special education teacher work together to assure the successful use of the equipment and the successful education of the child.

An occupational therapist may evaluate the child's coordination and train him in perceptual-motor skills, fine motor skills, and visual perception, with the objective of developing physical coordination. The special education teacher may train the child in the identical skills, but with the objective of achieving an academic goal. The means may be the same but the immediate objective, and hence the interpretation, is different.

The occupational therapist may use toys to evaluate a toddler's physical skill,⁷ perhaps noting the type of grasp the child employs. The special education teacher may use the same toys to obtain a measure of a specific cognitive skill, such as identification of shape or color. A child's performance on completion of a form board task can give the occupational therapist some information regarding gross coordination and at the same time give the special education teacher information regarding the child's ability to learn to discriminate a printed *b* from a printed *d*.

Occupational therapists are interested in the work skills and habits of their patients. Such characteristics as neatness, persistence, tolerance, ability to follow verbal and printed directions, and attitude are noted. Such information also interests the special education teacher. Independent evaluation of such skills and characteristics from the two different professional perspectives should lead to more accurate transmission of information to the professional persons involved in job placement. The student is the one who really profits from such cooperative endeavors.

Common attributes

While occupational therapy and special education are two distinct, yet complementary, professions, they have many attributes in common. Both professions require some kind of certification or registration to verify successful completion of a prescribed course of study. These courses consist of 4 to 5 years of instruction and on-the-job experience through clinical affiliation or student teaching under the supervision of professional persons on the job. The instructional programs of each profession provide opportunities for specialization. Some occupational therapists choose to treat patients in psychiatric settings; some special educators choose to teach emotionally disturbed children. Some occupational therapists choose to work with physically or mentally handicapped children as do some special teachers.

Another common attribute of the two professions is that both draw their treatment populations from persons victimized by society or nature. That is, the etiology of the handicap is imposed by the dominant culture or by genetics. Society's definition imposes the boundaries of "retardation" as opposed to "normality". Nature, that is genetics, may create the handicapping condition. But there are no socioeconomic boundaries among the clients of either profession. A cerebrovascular accident may impede the development of the rich or the poor, the gifted or the retarded. Mental retardation may occur in the family of a college president or a laborer.

There is a tendency now in special education to move toward preparing teachers who are generalists in the broad field rather than specialists in any one aspect of it; that is, to design instructional programs to develop teachers with the skills, abilities, and information necessary for teaching in *any* special class. Occupational therapy does this in its preparatory programs.

Workers in both professions profit from the assistance of subprofessional aides. Each profession has already established some training programs for aides and more such programs are being planned. Some of these inservice training programs are carried on in conjunction with colleges and universities; others are inservice based. I have been working under university auspices in an experimental program with six persons who have not had any college education to prepare them to function as special instructional personnel—not teachers, but more than aides—under professional supervision. An increasing corps of such subprofessionals must be trained to help meet the needs of the Nation's handicapped children.

Occupational therapists today are giving increasing attention to perceptual-motor functions or dysfunctions in relation to children's behavior, their relationships with others, and their academic achievement. Therapists administer perceptual tests of various types as well as tests of muscle function and motor coordination. Special education is also putting increased emphasis on perceptual-motor skills, but in relation to ability to achieve in reading, writing, arithmetic, and other subjects. Most students in special education today receive instruction and experience in the administration of a variety of tests, including perceptual tests.

Many special educators today are questioning the value of segregating handicapped children in special classes and are suggesting in their stead the use of resource rooms and itinerant teachers. The noncategorical generalist may replace the categorical specialist—that is, the same teacher may be assigned to the blind, the deaf, the mentally retarded, or the child with a perceptual-motor dysfunction. Moreover, the advent of programmed instruction may make teaching more of a science than an art. While the anxiety created by change may be a bit uncomfortable, a little anxiety can stimulate productive thinking and renewed effort.

Working relationships

Such similar goals and objectives, parallel programs, and merging functions necessitate a complementary working relationship between members of the two professions. Both use the same or similar material, albeit for different purposes. Throwing a bean bag into the clown's mouth may be used to release tension, to evaluate perceptual-motor skills, or to teach the concept of counting from one to five. Certain tests of visual perception may be administered

by either a qualified therapist or by a qualified special educator. The results may be used by both—but with different interpretations for different purposes.

When representatives of the two disciplines are working with the same child, planning the child's schedule is appropriately a joint endeavor. If the child has more than one handicap, they must consider the question of which disability is most important to attack—a judgment made on the basis either of severity or amenability to treatment. For example, if a child has both a physical and mental handicap but his mental retardation is the greater handicap, he is placed in a class for the mentally retarded. However, if his physical disability is a more severe handicap than his retardation, he is placed in a class with children having the same type of physical handicap. The same principle applies to scheduling academic and treatment programs—for children in whom the physical disability is the more severe handicap or the more amenable to treatment, occupational therapy takes priority, but if mental retardation is the crucial problem, special education may come first. Obviously, scheduling will not be the same for all patients or pupils in the same setting.

In my experience in a developmental evaluation clinic, the occupational therapist administered tests of visual perception, and the special education teacher gave the children classroom tasks to develop perceptual-motor accuracy and coordination while learning cognitive concepts—such as stringing beads to learn to count. The therapist prescribed the techniques to help the child carry out the assigned task—how to hold the bead and get it on the string. Both the therapist and the teacher employed reinforcement techniques—training or otherwise rewarding success—to change the child's behavior.

For different children, the division of tasks between the two disciplines might be quite different. How tasks are divided is determined by an evaluation of how a goal can best be achieved. Occasionally the occupational therapist and special educator perform identical tasks. However, when each uses her strongest skills in a working relationship, better service is provided the child.

One possibility for further improvement of the partnership might be a professional exchange in training or instructional programs. Occupational therapists who wish to work in schools might spend part of their clinical practice in a special education class. Special education teachers who wish to work with physically handicapped children might spend a portion of their field work in an occupational therapy

clinic. Students in either professional program interested in working with emotionally disturbed children or adults might be given opportunities to learn each other's techniques and frames of reference. Certainly the ultimate beneficiary of broadening the scope of knowledge and skill of both types of practitioner is the handicapped child.

About research

Research is an important aspect of both professions. Both are concerned with scientific inquiry—identification of problems, data gathering, formulation and testing of hypotheses, and the drawing of conclusions. Sampling problems, necessitating caution in making generalizations, are inherent in much of the present research in both professions. Such research, however, need not be limited to college and university settings, nor need it always involve intricate statistical calculations.

Statistical analysis is helpful, but the case study approach is also worthwhile. Based on in-depth description, a case study makes no attempt to compare individuals or specific traits among individuals. Comparisons are intra-individual rather than inter-individual.

Researchers in occupational therapy have tended to use the case study approach more frequently than statistical analysis but the reverse is true of the research workers in special education. No matter which method is used, however, research conducted by a team consisting of an occupational therapist and a special educator might be especially productive.

None of these joint endeavors is possible, and the efforts between representatives of the two professions to build up a salutary relationship will come to naught, without the cooperation and leadership of the administrators, the directors, and the supervisors of the programs. Such people hold the key to a creative working partnership between the two professions.

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NEW DIMENSIONS in STAFF DEVELOPMENT in a JUVENILE CORRECTIONAL SYSTEM

WALTER J. GRENIER

● Counselors, youth supervisors, and other employees in the Juvenile Division of the Illinois Department of Corrections are participating in the decisionmaking process on matters directly affecting the young people in their care. Through a comprehensive staff development program, these employees are learning to use management techniques of training, participation, and three-way communication to increase their competency.

In August 1969, the newly appointed administrators of the Illinois Youth Commission (now the Juvenile Division, Department of Corrections), identified staff development as a major priority and asked that it be initiated at once. Although there have been problems in implementing the program, staff development is now beginning to bring changes in the Illinois juvenile correctional system.

Inservice training, had, of course, previously been offered to employees, but it had been isolated from the Youth Commission's administration and so did not present the organization's philosophy and practices. Such training was often irrelevant, didactic, and scheduled irregularly. The instructors who came from universities and "outside" agencies seldom asked what the administrators of the correctional institutions were attempting to do, how they were going about their jobs, how they wished to be helped, or what their staffs needed to learn. Moreover, training was not geared to the levels of the variety of correctional workers who received it. But it seemed to matter very little to anyone that such programs showed questionable results.

The movement from classical managerial style to one compatible with treatment was accelerated through an Illinois Law Enforcement grant that provided monies to the Department of Corrections for holding American Management training workshops in the Juvenile Division. Starting with the chief executive and following levels of administrators, more than 50 executives were given in-house instruction in the fundamentals of management as practiced by modern industrial and governmental organizations. The introduction of the expanded dimension of

comprehensive staff development in the Illinois juvenile correctional system met with understandable resistance. In many institutions and offices the superintendents, department heads, and supervisors had long been accustomed to disregarding the ideas, skills, and experience of their staff. Their beliefs in hierarchical structures, coercion, one-way communication, close supervision, and other classical managerial practices collided with the staff development concepts of employee participation in the decisionmaking process, freedom from close supervision, open channels of communication, and consideration of employees' motivation and desire to learn.

From the failures of past efforts, the emphases for employee training programs could be pinpointed: process rather than one-shot efforts, the experiential rather than the didactic, harmonious administrative philosophy rather than authoritarian practices, and clearly stated goals rather than abstract principles. Furthermore, earlier programs showed that training needs to be supported by all levels of management and consistent with other parts of the system.

Fostering understanding

Staff development is a process designed to assist management in attaining organizational goals by helping employees function consistently through understanding their interdependent and interrelated roles. Training is legitimately concerned with all the elements that affect an employee's understanding, including his attitude toward his occupation. To be effective, staff development must provide comprehensive continuous training at the level where the employee is and an opportunity for the employee to participate in the organization and to be aware of his influence on it.

In efforts to bring employees to a higher point of development, the persons who plan staff development programs cannot ignore or circumvent conflicts between "new" processes and deeply entrenched beliefs of supervisors, clothed in authority. No upward movement by employees is likely to occur without the

enthusiastic endorsement of the supervisor, who—quite correctly—can hardly be expected to support processes contradictory to his own beliefs and experiences.

Thus, the planners who contemplate programs that would be more than window dressing—programs seriously proposing to move employees to a higher level of productivity—have to recognize that their performance is inextricably involved in and dependent upon management practices. So closely integrated are the concepts of staff development and management that it is difficult to differentiate the two: one may say that good management is good staff development.

It is unrealistic to expect results from a training program that promotes beliefs and practices alien to those of management—no matter how desirable other professional workers consider such beliefs and practices. Staff development properly has no identity except that of the organization's management; it is a supplement or extension of management and exists only to support the objectives of the administrators. It is incumbent on the administrators, therefore, to state explicitly the organization's program, its philosophy, and the practices necessary to achieve its goals. The staff development planners can then help carry out the design by assisting employees to understand management's objectives in relation to the employees' values and goals.

"People-changing processes" used in staff development programs need to be carefully structured for consistency. There can be little doubt that some management practices work effectively against staff development programs.

For example, conflict is almost inevitable when supervisors continue to advocate classical management practices and employees begin to adopt practices they have learned in training programs. Employees are often quick to accept sophisticated approaches to the treatment of young people in correctional institutions—such as methods of offering juvenile wards limited participation in the decision-making processes. The correctional unit becomes an arena of conflict as fundamental differences in theory divide the supervisors from the employees: autocracy vs. democracy, direct orders vs. two-way communication, red tape and official channels vs. an open structure that permits staff participation, and close supervision vs. trust.

Happily, there has been a convergence of thought between the field of management and that of cor-

rectional treatment within the last few years. Research has provided both fields with a much needed common basis for interaction. Studies have revealed that many classical management practices actually work against high production. For example, an employee works more effectively when he is given responsibility, trust, and a feeling that he is involved in decisionmaking than when he is manipulated, coerced, and closely supervised.

Management patterns

Rensis Likert, director of the Institute for Social Research at the University of Michigan, has pointed out how patterns of management are changing:

"The ability to exercise influence in an organization (how the employee feels he is able to influence the decisionmaking process—participative management) depends in part upon the effectiveness of its communication processes. It is not surprising, consequently, to find that influence shows a relationship to performance comparable with that shown by communication."¹

In describing the need for democratic principles Warren Bennis, provost of State University of New York, has stated: "Democracy becomes a functional necessity whenever a social system is competing for survival under conditions of chronic change."² He has listed three dimensions of change in American industry:

1. Full and free communication, regardless of rank and power.
2. A reliance on consensus, rather than on the more customary forms of coercion or compromise, to manage conflict.
3. The idea that influence is based on technical competence and knowledge rather than on the vagaries of personal whims or prerogatives of power.

Interestingly, these management principles mesh with behavioral research by Piaget on learning, Fiedler on relationship; Patterson, Rogers, Berenson and Carkhuff, Truax, and a host of others on human behavior. These investigators seem to agree that:

- Meaningful relationships between people are a prerequisite to growth, to development.
- People learn and become involved as they explore situations that are at their level of understanding and in which they can exert their influence.

● Meaningful communication can be promoted through safe, democratically structured meetings that are up and down and sideways, in groups that are small enough to allow interaction.

Consequently, management needs to guarantee each employee a voice in his activities, to help him become fully informed, to offer experiences and education that foster personal and job development in agreement with the organization's philosophy. Then, the employee, as a responsible person, is able to move in constructive ways. His values and attitudes, which have developed from the integration of his life's experience, determine how he acts in a particular situation.

Criteria

The Juvenile Division began its statewide staff development with a coordinated effort to involve all its employees in the formulation of a program statement—a blueprint to direct the more than 2,000 employees to work in a consistent, harmonious manner. Under the guidance of the newly established Office of Staff Development, an interconnected system of committees was set up in September 1969. Committee members represented employees from all levels and functions of the division's 21 program areas. These committees considered the following points in preparing their statement:

1. *Identification of an organizational goal.* When employees began working together to achieve a common purpose, they discovered that they held differing points of view regarding the juvenile correctional system. The widely held assumption that correctional employees pull together because they share common knowledge and common convictions was proven incorrect. Variations between employees' social, educational, and intellectual backgrounds were found to affect perceptions of their roles within the organization.

Obviously, the first task for management and staff development was to establish some degree of understanding of what holds employees together as an organization. There was a need to state the organizational goal in the clearest possible terms; such a statement could explain the reason for each person's employment within the organization. In identifying the goal, the committees worked out intermediate objectives, or subgoals. The committee members then decided means and alternative means for reaching specified objectives, and looked at such factors as

timetable, personnel and facilities required, capital and operating costs, standards, administration, and how to obtain accurate feedback that would help identify and modify deviations from the course established to reach the goal.

Administrators and staff development specialists promoted learning processes to help employees become more consistent in their behavior. As the employees began to benefit from staff development through increased understanding of the division's goal, they also began to recognize their own interdependency on and interrelationship with others in the organization.

2. *Communication.* The mortar that holds an organization together is communication: the more frequent and the clearer the communication, the better the possibility of the organization's attaining its goal. Unfortunately, many obstacles hamper effective communication, including:

● One-way communication. Many administrative messages have been understood only by the sender. In the absence of feedback, the administrator has been unaware of the misunderstandings, inaction, and other complex consequences of his message. Furthermore, some organizations have stifled employees' responses to management's communications. In recent years, an increasing number of administrators have encouraged messages to flow up to, as well as down from, management and to move laterally between employees doing similar work.

● Infallibility. Few supervisors willingly permit employees to question their judgments. The supervisors, in some mysterious way, are supposed to be endowed with extraordinary powers that enable them to function infallibly.

● Hearing. Listening habits are affected by the ways employees see themselves and other people: by their defenses, emotions, and biases; and by other distorting elements. Thus, many employees hear only a small part of what is orally communicated to them.

● Lack of opportunity for staff participation. Many units of the correctional system have not made

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adequate provision for staff members at all levels to engage in communication regarding their activities. Regularly scheduled staff meetings are one form of such communication often overlooked by supervisors in calculating staffing patterns and budgets. From a management viewpoint, staff meetings are an integral part of a correctional unit's operation.

● **Broad subject matter.** The range of problems prompted by the behavior of young people in a correctional institution raises an infinite number of issues. Employees tend to get lost in here and now problems unless they are given a clear frame of reference for resolving problems in a meaningful and consistent manner.

For example, a boy entering a correctional institution as a ward of the State wanted to keep his long hair. The supervisor focused the staff discussion of this problem on the Juvenile Division's program objectives. How would long hair affect the boy's adjustment to the institution? How would it affect the other wards? If the new ward was permitted long hair, should other wards also be permitted to let their hair grow? The matter was resolved, not on the caprice of the supervisor's personal value system, but as a result of a relevant staff discussion that determined medium-long hair did not interfere with the treatment program.

When discussions are channeled into an organized format, staff members can thoroughly explore the subject. To do this, however, a supervisor or staff development specialist must first make a complete examination of the program, and then match the immediate problem with the program framework.

A system approach, or system thinking, involves a step-by-step determination of goals, objectives, means to reach goals, alternatives, constraints, and implementation. In correctional systems, it can help employees become aware of their program's full potential. When employees have learned to apply system thinking, they can begin to examine their routine problems effectively.

3. Participative management (employee influence). Today many administrators are aware of employees' apparent need to know that they are recognized members of the organization and that they exert influence. Programs of participative management include open communication and feedback of employee ideas to administrators as well as supervisors. Logically, supervisors encourage as many employees as possible to participate in defining organizational goals, objec-

tives, and means, in staff meetings, and in decision-making processes. As employees work toward a consensus on goals, they gain a clearer awareness of their influence and a sense that the organization is theirs to support and defend.

A valuable byproduct of employee participation in the definition of program goals is that staff members learn more about their own jobs through hearing the debate of issues and principles that affect the entire organization. Any group of employees that attempts to define its organization's purposes soon finds that the discussions offer learning experiences unavailable in more formal educational programs.

Management theory and practice should approximate the values of our present day cultural beliefs: Democracy, self-direction, equality, and openness to new ideas are essential constructs for a modern correctional program.

Program statement

The Juvenile Division developed the following program statement: "The purpose of the Juvenile Division is to prevent and correct delinquent behavior by stimulating and implementing programs for youth designed to develop their knowledge, skill and emotional and physical well-being."

The Juvenile Division has further recognized its own responsibility in offering a broad range of social, educational, vocational, religious, recreational, and health services to the youngsters under its jurisdiction. Such programs are being designed to provide a continuum from the home to the institution and back to the community so that wherever practicable children are helped in their own families or at least in a community setting. When a child needs the protection of an institution, the division seeks to provide him with necessary services in milieu in which his individual needs may be met.

In support of the goal, a Juvenile Division administrator has written:

"Just as the dignity and worth of every individual is basic to our democracy, so is the dignity and worth of each youth basic to the concepts and objectives of this program. This is emphasized by providing opportunities to each youth to develop self-discipline and a sense of moral responsibility as an individual, as a member of a group, and a citizen of a democratic society.

"Each youth needs help in maturing toward the point where he can evaluate his own capabilities and behavior, accept responsibility for the latter, and enjoy the satisfaction of respect from others as well

as his own self-respect. To this end we must involve youth in defining their problems, in developing programs, and in the operation and the assessment of programs."

To reach the division's goal, the following objectives have been adopted:

1. The Juvenile Division will assist communities in identifying factors which contribute to delinquency; assist communities in establishing a broad range of community-based services for children, including medical, recreational, and social services; and serve in an advisory role for promoting legislation.

2. The Juvenile Division will—through professional consultants, various related organizations, and subsidies—develop and maintain effective liaison and close working relationships with the court services; mutually seek appropriate dispositions; assist in upgrading standards and practices; and help interpret court functions and responsibilities.

3. The Juvenile Division will provide residential treatment services to meet the physical, social, educational, vocational, and emotional needs of the youth committed for care.

4. The Juvenile Division will review and evaluate all services to provide management with a means to continuously update in accordance with the changing needs of youth.

5. The Juvenile Division will provide aftercare services which represent a continuation from residential treatment to successful adjustment in the community.

6. The Juvenile Division will promote a program designed to sensitize the public to their role in the support and implementation of services for youth.

7. The Juvenile Division will effect employment and staff development practices which assure that every employee realizes and achieves his full potential to contribute to the attainment of program goals and experiences the satisfaction of being a successful and helping person.

After analyzing the individual statements of goals and objectives of employee committees in the juvenile and other divisions of the Illinois Department of Corrections, State Director Peter B. Bensinger and his administrative staff developed an official statement that identified the organizational goal and ob-

jectives. According to the statement, the department's goal is "to serve society by (1) making available to each person within its areas of responsibility, all resources which will enable him to achieve human dignity and the capacity of leading a self-sufficient, law-abiding life, and (2) promoting an effective, efficient, and fair system of justice."

Application

Through broadly based, interconnected committees functioning in each of the Juvenile Division's 21 major program areas, a concerted effort is being made to establish staff development programs that fit employees' needs. These programs are providing the division with, among other things:

- Employees who are fully aware of organizational goals and objectives.

- Improved communication between administrators, supervisors, and employees.

- Recognition by supervisors and employees of the influence that each employee exercises within the program.

- Employees at all levels who are given responsibility, trust, and an opportunity to participate in decisionmaking in areas that affect them and their wards.

- Knowledge of a system approach to problem-solving.

- Growth-promoting relationships within the framework of properly structured meetings of employees.

The achievement of consistency vertically between employees, supervisors, and administrators and laterally between one employee and another is a primary goal of staff development. One measure of the effectiveness of staff development is the degree of variance or agreement that staff members establish between themselves and their administrators.

Although it is too early to measure the success of the Juvenile Division's efforts, the soundly conceived process of staff development is beginning to help workers to behave congruently with their stated purpose—consistency. And resting within the employees of the Juvenile Division is a nearly inexhaustible source of experience, ability, and integrity that can be channeled to develop an outstanding juvenile correctional system for Illinois.

¹ Likert, Rensis: *New patterns of management*. McGraw-Hill, New York, N.Y. 1961.

² Bennis, Warren: *Changing organizations*. McGraw-Hill, New York, N.Y. 1966.

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In "Erik H. Erikson: The Growth of His Work,"* Robert Coles indicates that he is attempting to write "... an intellectual biography of sorts." This history of Erikson's intellectual and scientific growth is impressive and informative, but not as impressive or informative as Erikson's original works.

Coles says in the preface, "... I have tried to look at the psychoanalytic and historical research and the ethical reflections of a clinician and professor I know and admire. I have hoped to give the reader in this one book a sense of what is found in five other books and in dozens of articles, monographs and essays. I have less thoroughly ... indicated something about the social and cultural history of psychoanalysis. God knows, a thorough intellectual history of the psychoanalytic movement needs to be done—by a historian free enough to be both sympathetic and critical."

As one can see from this introduction, the reader will have to be a person who enjoys Coles as well as one who is seeking the meaning and continuity of Erikson's splendid contributions to accept and absorb what this book offers.

Erikson, in the foreword to his most famous book, "Childhood and Society,"¹ states, "I came to psychology from art, which may explain, if not justify, the fact that at times the reader will find me painting contexts and backgrounds where he would rather have me point to facts and concepts. I have had to make a virtue out of a constitutional necessity by basing what I have to say on

representative description rather than on theoretical argument."

Here is one of the clues to why Coles' book was written and what it signifies, as well as why it has serious limitations. Erikson has steadily forged a chain of concepts about human development, an accomplishment that has required extraordinary versatility and the single-minded concentration of an artist. As an artist and scientist he has synthesized in his works the psychoanalytic studies of children and youth, anthropological observations, studies of several great leaders, and what he has learned from more than 40 years of gifted teaching of an unusually wide range of students. Robert Coles, himself a gifted writer and observer of children and their world, has been one of those fortunate students.

A sensitive profile

Inspired by and grateful to Erikson, Coles has made a valiant attempt to record for enlightened lay readers, as well as for professionals, an interweaving of Erikson's personal and professional development in relation to Erikson's major written works. The most effective part of Coles' presentation is the profile of Erikson as a young artist, as a psychoanalyst with a special interest in children, as a teacher of children, as an investigator of child life, and as a scholar searching for the critical connections between the child and adult, between man and his facilitating environment, between man and his historical realities.

It is in the sensitive apposition of Erikson's own life's experiences to his professional development that the book is most touching. Erikson's earlier life in Germany, his professional development in Vienna, the building of his own family with the warm and creative Mrs. Erikson are modestly etched in without invading the Erikson family's privacy.

Such biographical content gives us a basis for understanding, in a limited but important way, the complexity and

loyalty, the creativity and steadiness of Erikson as a pioneer and leading scholar of human development. We see Erikson the explorer wandering purposefully as he attempts to develop more adequate explanations of how man is formed by his experiential world as well as how man shapes his world and the world of others.

Erikson's explorations have rarely yielded to the temptation to simplify. With his scientific and clinical acumen and with his extraordinary capacity to synthesize—to paint contexts—he has been able to tolerate and work with the increasing complexity of variables as they have turned up in his clinical, anthropological, and scholarly explorations. While his published papers and books have a striking similarity to preliminary sketches, they are the watercolors and oils of a productive artist who is never satisfied. He refocuses old views while developing new ideas and new perspectives, adding to his methods whatever techniques or tools are necessary to critically examine and creatively express the relationship of man to his human, social, technological and historical world.

Erikson on Erikson

In his penetrating article, "Autobiographic Notes on the Identity Crisis" Erikson says this about the concept of identity: "It is a *sense* of personal continuity and sameness, but it is a *quality* of unselfconscious living, can be so gloriously obvious in a young person who has found himself as has found his communality." He adds, "It reaches both into the *past* and toward the *future*: It is grounded in the stages of childhood and will depend for its preservation and renewal on each subsequent stage of life. The 'socio' part of identity, on the other hand, may be accounted for in that communal within which an individual must find himself. No ego is an island to itself."

In the same article, Erikson says, "My own training in psychoanalysis was conducted by Anna Freud, who accepted

*ERIK H. ERIKSON: THE GROWTH OF HIS WORK. Robert Coles. Little, Brown and Company, Boston, Mass. 1970. 440 pp. \$10.

F ERIK ERIKSON

ne as a fellowship candidate, and this on the basis of the fact that she and her friends had approvingly witnessed my work with children both as a private tutor and as a teacher in a small private school. Anna Freud had founded the Viennese version of the subspeciality of child analysis, and I too, was to be primarily trained as a psychoanalyst of children. . . ."

He goes on, "The reader will appreciate the complex feelings aroused by the fact that my psychoanalyst was the laughter of the then already mythical founder [of psychoanalysis] While such a preparation is of the essence in his kind of work, and while this essence can up to a point be comprehended in a systematic and disciplined way, it stands to reason that the generational succession of teachers, so important in all fields, will remain a special burden in the life of any maturing and even of the trained psychoanalyst—a burden seeping well into the conceptualizations he may later feel called upon to confirm or to disavow. Even the most venerable training psychoanalyst is (and must be) both welcomed as a liberating agent and resisted as a potential indoctrinator, and thus he both accepted and rejected as an identity model; for in all pursuits which attempt to gain a rational foothold in man's pervasive irrationality, insights retain an unconscious involvement which can only be clarified by lifelong maturation. At the same time, however, only the systematic clinical acquaintance with the unconscious can convey a certain ceaseless surprise over the creative order that governs affects never faced before and a certain sense of liberated sanity just because of the chaos faced. This is probably hard to comprehend except through the experience itself; and yet some of it must be visible in the impact of psychoanalysis on other fields and the augmented access it has provided to a wealth of data previously not visualized or not seen in their relation to each other."

In a summarizing paragraph, Erikson explains the purpose of this review of

his work thus far. ". . . I have recapitulated my conceptual ancestry insofar as it originates in psychoanalysis, in order to indicate that psychoanalysis represents a very special admixture of 'laboratory' conditions, methodological climate, and personal and ideological involvement. Other fields may claim to be governed by radically different admixtures and certainly by much less subjective kinds of evidence. But I wonder whether they could insist, at any time, on a total absence of any one of the ingredients described here."

In this overview Erikson has clearly outlined what he terms ". . . significant theoretical differences between the classical psychoanalytic outlook and newer perspectives such as my own" under the following categories: (1) *Superego and Identity*; (2) *Clinical and Actual Reality*; (3) *The Inner and the Outer World*; and (4) *The Ego and the I*.

Some reservations

I have quoted Erikson at some length in order to demonstrate that there is no substitute for the "master." Robert Coles acknowledges this by using many direct quotations from Erikson's writings. However, a limitation of Coles' book is that its efforts to summarize, translate, and synthesize Erikson's contributions and point of view cannot compare favorably with the "original," the authentic Erikson works, which are available to the same people to whom this book is addressed.

The reason Coles' book almost succeeds and will be valued by many who read it lies in Coles' own career and works. He, too, is an explorer, a literary person, and an important humanist of our times.

My main reservations are that Coles continuously reveals a personal attitude toward psychoanalysis that is not appropriate in a book devoted to the growth of Erikson's work. Repeatedly, Coles praises Freud and Erikson, and then almost as a reflex, comments on his disappointment in certain analysts



Erik H. Erikson

or in certain aspects of psychoanalytic practice. Robert Coles is also searching for an understanding of the individual and the world that shapes him and the crucial ways in which the individual is shaped by his microcosm and the macrocosm.

Nevertheless, Coles is a man to be admired and understood as he tries to utilize clinical understanding, literary competence, and a sense of social history and injustice to put our best knowledge to work in the service of children, the poor, and all the anonymous persons in need of care and justice. Perhaps, this is why he has a tendency to see social phenomena and man's cruelty to man in the context of heroes and villains.

As an essayist who has commented widely on the current social scene, Coles has provided us with an interesting and timely profile of Erikson and his work.

¹ Erikson, Erik H.: *Childhood and Society*. W. W. Norton and Company, Inc., New York, N.Y., 1950.

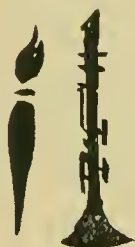
² ———: "Autobiographic Notes on the Identity Crisis." *Daedalus*, Fall 1970.

Quotes From the 1970 White House Conference on Children



To a child, his body and what he can do with it *is* his identity. Most of his activities—play, artwork, dance, “self-expression”—depend on physical motion and aid his development of confident, skilled muscular movement and control. pp. 44-45.

The right to learn is the goal we seek for the 21st century. We want for our children a range of learning opportunities as broad as the unknown range of their talents. We want a learning environment that nurtures those talents. We want our children . . . to have freedom, and the order, justice, and peace that the preservation of their freedom demands. p. 75.



The creative child whom we wish to nurture is curious, wonders, and questions; seeks new experiences; is open to the world; independent and free from social and group pressures to conform at the cost of individuality; willing to risk error, play with ideas, and experiment; willing to change and live with change. p. 97.

Our nation has achieved almost universal school attendance. We must turn our attention to quality in education by focusing more on the one school child out of four who suffers serious reading difficulties. p. 105.

Let us move toward a multifaceted educational system incorporating what we know of human diversity, with mechanisms for choice and change. p. 132.

Our need, then, is to provide *all* health services to *all* children and to make sure that *each child uses* what is available and needed. p. 185.

All injuries should be viewed as symptoms of environmental deficiencies to be corrected by the adult community. p. 214.

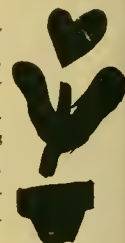
The gap between the options for self-fulfillment we want for children and those they presently receive must be drastically reduced. Recognizing and accepting basic changes in our values and goals is a beginning step. . . . Our people and our systems which provide educational and other human services must revise programs, policies, and practices to reflect the differing achievements, contributions, needs, and aspirations of all the groups that make up our society. p. 227.

We like to think of America as a child-centered society, but our actions belie our words. A hard look at our institutions and way of life reveals that our national

priorities lie elsewhere. . . . *children and families all too often come last.* p. 241.

Few actions of the next decade will be more crucial for the welfare of America's children (and the world's children) than what we do about two of the most basic determinants of the quality of life of our children and their family: *distribution of income* among families by our society and *size* of both our families and our society. p. 259.

Children have a right to grow up in a society which stresses moral and ethical values, which teaches the concepts of love of fellow man, which respects the right of individual religious beliefs, which develops the child's personality to include the virtues of honesty, integrity, good character, fairness, compassion, and understanding in all human relations. p. 304.

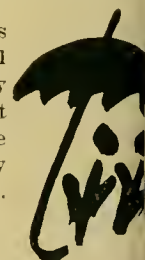


. . . public policies and programs and our actions as individuals shape a world in many ways inhospitable, indeed often hostile, to the life of children and their full creative growth. p. 307.

Current products of mass media reflect insufficient empathy for the inner needs of children and for the needs of their parents. p. 326.

. . . It is imperative that a national commitment be directed to develop a leisure which permits every child to sample and explore a variety of beneficial experiences. p. 335.

Our consideration of children's rights is based on a knowledge of their developmental needs and characteristics. . . . Public policy and action—Federal, state, and local—must rest upon this knowledge if it is to provide our children the opportunities for healthy growth, internal well-being, and fulfillment. pp. 345-346.



Neglect of children in trouble and in need produces misfits, drifters, welfare cases, delinquents, and criminals. The result is . . . a tragic squandering of human potential. p. 377.

“Report to the President: White House Conference on Children.” 1971. 451 pp. For sale: \$4.75. Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

BOOK NOTES

THE UNMARRIED FATHER: new helping approaches for unmarried young parents. Renben Pannor, Fred Massarik, and Byron Evans. Springer Publishing Company, Inc., New York, N.Y. 1971. 196 pp. Cloth \$6.25; paper \$4.25.

This book reports on a 3-year study of the parents in 222 out-of-wedlock pregnancies, with a focus on the unmarried father. Conducted by the Vista Del Mar Child-Care Service in Los Angeles and the Jewish Federation with support from the Children's Bureau, the study includes 96 unmarried fathers who were involved in counseling by male social workers and the 222 unmarried mothers who received help.

The authors find that the unmarried father is "reachable" by a social agency properly motivated; that the mother's decision about the future of the baby is not significantly affected by the involvement of the father, although having the father's support is of considerable psychological help to her; and that the father generally is willing to contribute financially when able to do so. A psychological profile of the unmarried father shows that he has not developed a strong identity. About half of the unmarried fathers in the study lived in homes where the fathers were absent or deceased.

ENCYCLOPEDIA OF SOCIAL WORK. Second edition. Robert Morris, editor-in-chief. National Association of Social Workers, 2 Park Avenue, New York, N.Y. 10016. 1971. 1,728 pp. in two volumes. \$22.50.

This two-volume encyclopedia presents 180 articles relating to social work and social welfare philosophy and practice in the United States, 105 biographical sketches of persons who influenced the development of social work, and 52 statistical tables. Almost 200 persons contributed to the 1971 edition—social workers, educators, research workers, economists, psychiatrists, psychologists, historians, city planners, political scientists,

statisticians, and a labor leader.

In the preface Robert Morris, editor-in-chief, explains that this edition seeks to "draw together in some understandable relationship the professional practices of social work, the social problems and welfare institutions of our day, and the realities of the wider social, political, economic, and physical environment."

Key subject areas covering broad aspects of social welfare are arranged alphabetically. Seven articles deal with child welfare: a general article, and child welfare as related to adoption and foster care, child-care workers, day care of children, institutions for children, preschool programs, and residential treatment homes. Nine articles are included under the entry "family." Among other key subjects: crime and delinquency, financing social welfare, health care system, housing, labor force, mental health and illness, profession of social work, poverty, public assistance, and youth service agencies. A comprehensive index is included.

HELPING UNMARRIED MOTHERS.

Rose Bernstein. Association Press, New York, N.Y. 187 pp. \$6.95.

This guide for persons who deal with unmarried mothers explores the psychological and social hazards of having a child out of wedlock and the factors that determine whether the woman receives the services she needs. If help is given promptly and unconditionally, the author suggests, more unmarried mothers will emerge from their experience "with a sense of growth and with hope for the future."

The author describes the methods of crisis intervention she developed as a social worker in a Boston maternity home—methods that emphasize major decisions to be faced and the unmarried mother's perception of herself in a maternal role. Special problems of the adolescent unmarried mother are presented. The author discusses how agencies respond to a pregnant woman's request for

help; plans for the baby; the aftermath of nonmarital pregnancy for the mother who keeps her baby as well as for the mother who releases her baby for adoption; the mother's changing relationship with the unmarried father; and coordination of community resources to serve unmarried mothers.

THE CHILDREN OF KAUAI: a longitudinal study from the prenatal period to age ten. Emmy E. Werner, Jessie M. Bierman, and Fern E. French. University of Hawaii Press, Honolulu, Hawaii. 1971. 199 pp. \$7.50.

This book describes a comprehensive study of the outcome of all known pregnancies on the island of Kauai in 1954, 1955, and 1956. A multidisciplinary team of pediatricians, psychologists, public health nurses, and other workers from the Universities of California and Hawaii directed by the authors identified 2,203 pregnancies that resulted in 1,963 live births. To determine the effect of birth trauma, environment, and ethnic and cultural differences on the maturing child, the team assessed the physical, cognitive, and social development of more than 1,000 children at the ages of 2 and 10.

The authors found that 90 percent of the fetal losses occurred in the very early weeks of pregnancy, that early environment played a crucial role in influencing child development—10 times as many children had problems arising from the effects of a poor environment as from the effects of serious perinatal stress, and almost one-third of the 10-year-olds need long-term remedial education or mental health services.

THE CHILD IN HIS FAMILY. Volume I, The International Yearbook for Child Psychiatry and Allied Disciplines. Edited by E. James Anthony and Cyrille Koupernik. John Wiley & Sons, Inc., New York, N.Y. 1970. 492 pp. \$12.50.

The 22 papers in this volume describe variations in the structure and function of the family unit in many parts of the world as they affect the development of the child. The contributors—psychiatrists, psychoanalysts, psychologists, anthropologists, and other behavioral scientists—agree that the family is in the process of change but do not agree on whether the change is in the direction of improvement or eclipse.

HERE and THERE



Associate chief

Frederick Chapman Green, formerly a practicing pediatrician who for the past 5 years has been engaged in the planning and delivery of comprehensive medical care to children of low-income families in New York City, became associate chief of the Children's Bureau in the Office of Child Development in August.

In announcing the appointment, OCD Director Edward Zigler said one of Dr. Green's major responsibilities will be the National Center for Child Advocacy. The center will have three subdivisions: a Children's Concern Center that will channel Government response to questions and ideas about children from parents and citizens, a Secretariat that will draw together information about children and children's programs, and a Division for Vulnerable Children who "need advocacy 365 days a year."

Dr. Green was director of the child and youth project at the Roosevelt Hospital in New York City from 1967 to 1971, and at the same time served as the hospital's director of pediatric ambulatory care. His previous hospital staff appointments included New York Hospital; Sydenham Hospital, where he was director of the department of pediatrics; and Harlem Hospital, where he completed his internship and residency in pediatrics. He earned his M.D. degree from the University of Indiana School of Medicine in Indianapolis, and later took postgraduate work in pediatrics at Harvard University School of Medicine.

A fellow of the American Academy of Pediatrics, Dr. Green is also active in a number of other professional organizations, including the American Medical Association, the National Medical Association, and the American Public Health Association. Because of his experience in

working with unmarried teenage mothers at Roosevelt Hospital, he has served as leader of several national conferences on parenthood in adolescence. Dr. Green is a consultant to HEW's maternal and child health research advisory group. He has written and lectured on many aspects of child health.

Dr. Green has also been a clinical associate professor of pediatrics at Cornell University School of Medicine and has taught at Harlem Hospital, Fordham Hospital, and Hunter College Schools of Nursing.

Dr. Green was born in Fort Wayne, Ind., and attended high school in Battle Creek, Mich., and Fort Wayne. He is married and has two children.

Home Start

The Office of Child Development is planning to launch an experimental home-based variation of Head Start during the fiscal year 1972. Under the program, to be called Home Start, paraprofessionals trained in child-development techniques and homemaking skills will assist low-income parents in providing developmental experiences for their preschool children.

Initially Home Start may serve as many as 3,000 children between birth and 5 years of age in about 15 programs operating out of existing Head Start centers. In addition to the paraprofessionals' work in the home with parents and children, the programs will provide a variety of interrelated activities in Head Start centers emphasizing the development of the family's ability to provide continuing developmental experiences for the child. Every child in Home Start will receive the comprehensive medical, nutritional, and social services associated with Head Start and—as in Head Start—parents will be

involved in planning, operating, and evaluating the program.

Day care

A national conference on day-care licensing will be sponsored by the Office of Child Development in San Antonio, Tex., October 27-29. Licensing specialists have been working as members of OCI task forces since early summer to develop national standards for zoning, fire safety, building construction, and other elements of day care subject to licensing. They will present their recommendations for nationwide licensing code at the conference.

About 150 invited representatives of national day-care organizations and State and local agencies concerned with licensing are expected to attend. Follow-up regional conferences are planned.

Research grants

The Children's Bureau, Office of Child Development, has awarded 41 new grants totaling \$3.5 million for research and development projects in the areas of child development and child welfare during the 1972 fiscal year. An additional 16 grants totaling \$2 million were renewed for projects already underway.

These projects were selected from 1 applications, which were reviewed by a committee of specialists from outside the Office of Child Development. All programs are administered through the Research and Evaluation Division.

Awards totaling \$824,717 have been made for Model Cities programs. These include a \$100,000 contract between the Department of Health, Education, and Welfare and the Department of Housing and Urban Development for technical assistance through OCD's 4-C (Community Coordinated Child Care) programs to help plan and implement programs in day care and other aspects of early childhood development in Model Cities areas in 10 States.

The new projects include:

Day care

A program to provide model day care that focuses on close human relationships available for 3- and 4-year-old children. Reiss-Davis Child Study Center, Los Angeles. \$67,146.

A demonstration project to introduce a cross-age helping relationship for teenagers and elementary school children in afterschool day care. National Comm-

tion on Resources for Youth, New York City. \$33,250.

A project to recruit and use male workers in day care. Emory University, Atlanta. \$39,965.

An infant satellite component to establish six infant day care homes. University of Hawaii, Honolulu, Hawaii. \$71,501 (supported with Model Cities).

A project to determine whether a community corporation can operate a child care facility. National Urban League, New York City. \$74,957.

Demonstration projects to design new methods of coordinating 4-C activities in Model Cities programs serving Bexar County, Tex.; Hidalgo County, Tex.; Athens-Clarke County, Ga.; and Winston-Salem, N.C. \$136,154.

Health

A project dealing with special medical and counseling needs of teenagers in a center that involves other young people in delivery of services. Children's Health Center, Minneapolis. \$72,460 (Model Cities).

Family development

Curriculum research in infant education. Yale University, New Haven, Conn. \$129,828.

A study of cognitive development and mother-child interaction in a group of culturally deprived infants. The Johns Hopkins School of Medicine, Baltimore. \$54,200.

A study of parent attitudes and developmental changes in children during enrollment at a children's physical developmental clinic. University of Maryland, College Park. \$15,848.

A project to evaluate a family development center that provides services to infants and their teenage mothers who are continuing in high school. Family Service Agency of San Francisco. \$268,739.

Programs on preparation for parenthood and early childhood development, including an infant center, in a laboratory school for teenage pregnant girls and mothers. Macon County Board of Education, Tuskegee, Ala. \$129,813 (Model Cities).

A project to develop and evaluate a family service center that acts as a family advocate and clearinghouse for service information and referral. Community Coordinated Child Care Agency, Juneau, Alaska. \$60,361 (Model Cities).

A preparation for parenthood project, to demonstrate a comprehensive service

program for pregnant teenage girls. Waco Independent School District, Tex. \$59,225 (Model Cities).

Advocacy

A program to provide training in child development to mothers in the waiting rooms of pediatric clinics. Mount Sinai School of Medicine, New York City. \$73,380.

A conference on planning for research in child development for the 1970's. University of North Carolina, Chapel Hill. \$6,000 (with National Institute of Child Health and Human Development).

A comprehensive service program to involve youth in social decisionmaking processes, crime prevention, employment, advocacy, and other activities they select. Youth Service Agency, Rock Hill, S.C. \$38,480 (Model Cities).

A pilot project to provide an after-school recreational and remedial program for preadolescents. Youth Services Agency, Newark, N.J., \$72,780 (Model Cities).

An exploratory survey of programs and activities that might be considered child advocacy systems. Columbia University School of Social Work, New York City. \$97,646.

A conference on Youth in the 1970's to identify and analyze major issues related to youth and to develop policies and programs. University of Minnesota, Minneapolis. \$5,225.

A data system for planning research related to children. George Washington University, Washington, D.C. \$166,579.

Vulnerable children

A followup study of black children adopted by white families. Child Welfare League of America, New York City. \$84,228.

A project to design and evaluate a program to teach adolescents how to assume responsible roles in caring for younger children. Education Development Center, Cambridge, Mass. \$364,895 (with National Institute of Mental Health).

A project to assist in the establishment of a national foster parent association. Child Welfare League of America, New York City. \$93,520.

A study of the utilization of subsidies to increase adoptions of black children. Illinois Department of Children and Family Services, Chicago. \$129,277.

A project to develop and evaluate comprehensive 24-hour emergency services to neglected and dependent children.

Davidson County Office, Tennessee Department of Public Welfare, Nashville. \$218,363.

A project to serve children-in-crisis with 24-hour emergency social service. Children's Aid and Society for the Prevention of Cruelty to Children of Erie County, Buffalo, N.Y. \$151,658.

A survey and evaluation of the use of community-oriented care by institutions for dependent and disturbed children. Georgia State Department of Family and Children Services, Atlanta. \$125,660.

A project to test advocacy techniques in stimulating adoptions of black children. Black Child Development Institute, Inc., Washington, D.C. \$70,470.

A project to develop and evaluate a Child Advocacy Center for the State of Connecticut to serve the needs of children from birth to 7 years of age. Connecticut Child Welfare Association, New Haven. \$79,700.

A project to identify areas of knowledge and practice in child development that are under-utilized by institutions working with children. Human Interaction Research Institute, Los Angeles. \$61,145.

A project to increase the effectiveness of ARENA, the Adoption Resource Exchange of North America, which is concerned with the interstate adoption of children. Child Welfare League of America, New York City. \$29,197.

Miscellaneous

A reanalysis of research related to the roles of race and environment in the development of cognitive abilities. University of Texas, Austin. \$52,123.

A project to test remediation techniques in helping children who have learning disabilities or potential learning disabilities. Androscoggin County Task Force on Social Welfare, Inc., Auburn, Me. \$83,943 (Model Cities).

An evaluation of 4-C Model Cities projects that provide services to meet children's educational and social needs. Child and Youth Development Institute, Nashville, Tenn. \$48,850.

A project using residents of the Holly Park Community as child advocates. University of Washington School of Medicine, Seattle. \$106,199.

A study of the ways professional persons and the public acquire information on child health, specifically the "Report of the Conference on the Use of Stimulant Drugs in the Treatment of Behav-

iorally Disturbed Young School Children," issued in 1971 by OCD. George Washington University, Washington, D.C. \$42,416.

A research utilization and information-sharing project to stimulate the development and exchange of knowledge in infant intervention and adolescent parenting among professional researchers. George Washington University, Washington, D.C. \$76,677.

Juvenile trials

Trial by jury in a juvenile court is not a constitutional requirement, the Supreme Court of the United States ruled in a 6-3 decision June 21, 1971, in *McKiver et al v. Pennsylvania*. The Court rejected appeals for juvenile jury trials in two Pennsylvania cases and one North Carolina case.

In the majority opinion, Justice Harry A. Blackmun held that if the formalities of the criminal adjudicative process are to be superimposed upon the juvenile court system, there is little need for its separate existence. Moreover, the opinion pointed out that the requiring of a jury trial would undermine the juvenile court's assumed ability to function in a unique manner, without greatly strengthening its fact-finding function. The Court observed that there is no constitutional barrier to prevent a juvenile court judge from using an advisory jury, however.

Family and child services

The Children's Bureau, Office of Child Development, and the Community Services Administration, Social and Rehabilitation Service, have recently issued a guide to serve as a tool for public welfare agencies in planning to expand and improve the quality of their service programs with the use of a wide range of both professional and subprofessional staff as required by regulations of the Department of Health, Education, and Welfare.

The guide points out that two of the major problems facing the agencies in this period of change are: (1) the determination of what services the agency should and can provide; and (2) the selection and training of staff for effective performance. To help in the solution of these problems the guide presents a way of using the process of systems analysis to examine the agency's purpose, goals, and objectives and to

identify what must get done to achieve these objectives—in other words, to find out what services the agency must provide to meet its obligation to the people it is designed to serve and what will be required to provide them.

The guide describes a method of functional job analysis to define the tasks that must be performed by staff members of various levels of education and experience to get the work done. Appendices include examples of task statements, performance standards, knowledge and skills required and level of complexity of tasks in selected areas of family and child welfare services.

The purpose of the guide is to help social agencies, public and voluntary, serving children and their families to pursue an orderly, disciplined approach in program planning, service delivery, and differential use of staff.

Annie Lee Sandusky was chairman of the staff committee that prepared the guide. ("The Differential Use of Staff in Family and Child Welfare Services, with particular reference to subprofessional staff: a guide." Copies are available on request from the Children's Bureau or CSA.)

Retarded children

Mothers and teachers who work together systematically to reinforce appropriate behavior in the home and in the classroom can change a severely retarded child's bizarre life style to a more socially acceptable one, as shown in a demonstration conducted by the Exceptional Children's Foundation of Los Angeles.

Five of the six children whose mothers participated in a 1-year behavior modification training program in 1969 were able to enroll in public school classes for exceptional children the next year.

The mothers' training was tied to a special class for children between the ages of 8 and 12 who had been diagnosed as autistic, schizophrenic, aphasic, or severely retarded, but were still living at home. Sponsored by ECF, a voluntary agency serving the mentally retarded, the children's class was conducted by a teacher and an assistant skilled in using reinforcement methods to achieve specific behavioral objectives.

The mothers, the teacher, a psychologist, and a social worker held weekly group meetings. Each mother also worked in the classroom at least once a

week on a regular schedule. After observing how the teacher used behavior modification methods to help a group of children and an individual child perform an assigned task, each mother worked with a group and an individual child under the supervision of the teacher. Finally the mothers used reinforcement methods without supervisor to teach a task to a group, an individual child, and her own child.

An important part of the program contract was the mothers' agreement to engage in specific behavior modification tasks at home as a carryover of the work in the classroom. Each day the teacher prepared an individual, written prescription of a task for each child. At home the mother worked with her child on the task for a specific time or until it was completed; then she wrote a brief assessment of her child's progress and returned the prescription form to the teacher the next day. Assignments and prescriptions were changed by the teacher based on the feedback received from the mothers. Mothers and staff member reviewed their successes and failures at the weekly group session.

By the end of the year, the children had made measurable gains: all had reduced their bizarre behavior—arm flapping, rocking, uncontrollable rages, and so forth; they had also lengthened their attention span, learned to follow directions and complete assigned tasks, established eye contact with others, improved their speech, and begun to interact with other children.

Further information may be obtained from Molly C. Gorelick, Ed.D., associate professor, who directed the program (Address: Preschool Laboratory, San Fernando Valley State College, Northridge, Calif. 91324.)

Health Start

Since its introduction in July 1970, Health Start has provided comprehensive medical and dental services to more than 12,000 disadvantaged preschool children through 28 projects supported by the Office of Child Development in the 10 HEW regions. With the initial physical and dental examinations and vision and hearing screening in most projects now completed, Health Start coordinators are making sure that followup care will be provided throughout the year to meet medical and dental needs of the children.

The seven urban and 21 rural area projects have been set up in a variety of settings—a day camp in Penobscot County, Maine; the Tot Lot play center in Flint, Mich.; a health center in Rio Piedras, P.R.; a migrant camp in The Dalles, Oreg.; Head Start and community health clinics; and even the children's own homes. Health Start staff members—nurses, health aides, and teachers—have involved the entire family in the fundamentals of health care.

In addition to its own staff, each Health Start project has drawn on community health resources, including pediatricians, dentists, nurses, medical and dental students, State and local public health departments, medical clinics and hospitals, and volunteers for immunizations, blood tests, medical and dental examinations, and other specific services.

Miscellaneous

On June 30, 1971, President Nixon signed Public Law 92-31, extending the Juvenile Delinquency Prevention and

Control Act of 1968 for 1 year. The new law authorizes appropriations up to a total of \$75 million for activities related to preventing and reducing juvenile delinquency. It also sets up an interdepartmental council to coordinate all Federal juvenile delinquency programs, authorizes the Secretary of HEW to make grants up to 75 percent of the cost of rehabilitation projects and delinquency prevention programs, and allows nonprofit private agencies to receive Federal funds for rehabilitation programs. The Youth Development and Delinquency Prevention Administration of HEW is charged with administration of the act.

• • •

Neighborhood Youth Corps members in 14 metropolitan areas have been using "Sesame Street" to tutor innercity preschool children during the past summer. A recently completed \$600,000 national project conducted by the Department of Labor's Manpower Administration involved 1,500 high school students and 15,000 preschool children.

With their pupils, the NYC "teachers" watched the educational TV series each weekday in day-care centers and established viewing centers in store fronts, libraries, private homes, and public housing developments in innercity neighborhoods. Then the "teachers" directed the younger children in games that call for letters, numbers, geometric forms, and other information presented on "Sesame Street," using a curriculum developed by the Children's Television Workshop. The NYC members were paid an average of \$10 a week.

Correction

Through a typographical error in the July-August 1971 issue of *CHILDREN*, Elliot Liebow was incorrectly identified in Cecelia E. Sudia's article, "Minorities Achieve the Right to Question Achievement," (p. 155). Dr. Liebow is chief, Center for Studies of Metropolitan Problems, National Institute of Mental Health; Bertram S. Brown is director, National Institute of Mental Health.

READERS' EXCHANGE

GRAY: conflicts in values

Susan Gray is to be complimented for having thought through some of the ambiguities that surround intervention research with young children and some of the conflicts that researchers who enter this area must learn to live with in a modest degree of comfort. ("Ethical Issues in Research in Early Childhood Intervention," *CHILDREN*, May-June 1971.)

Dr. Gray acknowledges the obligation of researchers to recognize the legal and moral authority of the parent to speak for the child—to give or withhold permission to participate in programs, to seek or avoid involvement with an intervention program, and so forth. No one would question the validity of that parental right. But the researcher will be put into serious ethical conflict about his responsibility to the children when the exercise of parental rights appears to jeopardize the welfare of the child.

Consider an example from our pro-

gram: a 2-year-old boy came to the day care center one morning with bruises over his arms and legs and a cut above his right eye wide enough to require sutures. His mother said a neighbor child had hit her son with a stick. When the school nurse said the cut needed immediate treatment, the mother replied that she could not afford to leave work to take the boy to the emergency room. Although the parents had authorized our center authorities to act in a medical emergency, the doctors would not treat the injury without the mother. Center staff members were forced to defer to the parental right not to act.

A second kind of conflict-arousing situation relates to parental action that sabotages objectives of the intervention program. An example is the parent who castigates the teacher for not using physical punishment. One mother withdrew her daughter because we would not "beat" the child when she had a toilet accident.

Other more subtle but perhaps more

damaging kinds of sabotage can also occur. A 5-year-old girl in our kindergarten one morning identified children that she could not play with. The children on the forbidden list, all of whom were black, soon felt the impact of rejection. Were we failing to respect the parent's rights to speak for their child when we tried to help them understand the effect of such an edict on the rejected children and the center?

A similar type of conflict may occur when the parent does not share the researcher's convictions about the value of the intervention. Some parents bring the child only one day out of five, thus preventing both their own child and another child who otherwise would be enrolled from taking advantage of the program. Such behavior characterizes the families most in need of the very experiences provided by intervention. Can the intervener ethically remain passive? Or should he try to persuade the parents of the value of the intervention?

Dr. Richard Elardo and I are currently collecting data to determine whether there is any empirical validity in the oft-stated accusation that intervention programs are predicated on middle-class values and parents of the

participating children do not share these values. Our early findings suggest that the parents of children in our intervention project share the staff's objectives for their children.

The risk-benefit ratio, a term used in the American Psychological Association Code of Ethics, offers a guideline for intervention. If the presumed risk is great and the potential benefit small, obviously no intervention should occur. Nor should intervention occur if risk and benefit are presumably equal. If the potential benefit exceeds the risks, however, the researcher is not only free to intervene but is perhaps obligated to do so. I am grateful to Dr. Gray for reminding us of the conceptual formula.

Delaying field tests with human subjects until the possible risk-benefit ratio is clearly on the side of benefit should solve some potential conflicts in research. If the researcher makes certain that he has taken all the necessary preliminary steps, he should have few scruples about seeming to abandon impartiality and objectivity as he advocates intervention. In this context he will be acting as an advocate for the welfare of the children involved in his research.

*Bettye M. Caldwell
Director, Center for Early
Development and Education
Little Rock, Ark.*

GRAY: broad intervention research

It was indeed refreshing to read Susan Gray's article. As a pioneer in the modern field of intervention research, Dr. Gray has a wealth of experience to share; as a sensitive and humane person, she has conceptualized many of the ethical issues left unheeded by the majority of researchers in this field today.

Dr. Gray elaborates the concept "you can't do just one thing" by pointing out that "no matter what the point of entry, when one is trying to make profound changes in a system, one must work with due regard to all the aspects of that system, including the relationships involved." It seems to me that this has been the most neglected thought in intervention research. We have repeatedly seen projects suffering from theoretical narrowness—projects that supposedly foster intellectual development but pay no regard to the children's personal and social growth, their nutritional status, or the importance of their parents.

Recently, a trend to including the mother in the so-called home intervention projects has appeared but I have rarely seen a report of a project that tried to involve fathers. Apparently, in such research little thought has been given to including the question of how the various members of a family affect each other and to examining the possible destructive results on a family system of marked changes in only one member.

One issue involved in working with parents is the controversial problem of parental control of programs. Nothing is more likely to raise cries of anguish. Many professional persons have failed to think clearly about what they know theoretically: that the most effective way of changing a disadvantaged person's sense of hopelessness and lack of control over his life is to allow him to experience in a *real* way a situation in which he does have control.

The arrogance of professional persons who say in effect, "parents don't know what's best for them," or "they'll make mistakes" is agonizing to behold. What professional person always knows what is best, or doesn't make mistakes? Serious respect *must* be paid to the process by which people learn and change—by taking responsibility for their behavior and then suffering or thoroughly enjoying the consequences.

The cultural inappropriateness of many current intervention projects—in family homes, day care centers, and schools—derives from a lack of respect for differences in people. Dr. Gray clearly speaks to the importance of cultural pluralism.

Finally, I would stress the importance of research persons becoming lobbyists who say loudly and clearly what we know about the costs to society of not intervening to eliminate the "disadvantages" hampering children's development. Dr. Gray notes ruefully that intervention is not popular anymore. The extreme importance of social change agents must not be forgotten, no matter what the political climate.

*Dorothy S. Huntington
Chief, Child Development Section
Children's Hospital of D.C.
Washington, D.C.*

An agency's efforts

In connection with the Children's Bureau's current interest in uncovering adoption resources for black children, I would like to describe the efforts that

our agency has been making since last fall to recruit black families in North Carolina for adoption. Among other steps these efforts have included:

- Organizing concerned black groups throughout the State to interpret the needs of homeless black children.

- Entitling the aid of the organized black groups in critically examining our past and present practices for possible deterrents to applications from black families.

- Adjusting agency practices that have kept families away, for example: revising rigid application procedures; making intake procedures more flexible on receipt of the application; having a worker available for the home study at hours convenient for the prospective adoptive parents; adopting an accepting attitude toward the "life style" of black families; and conveying an encouraging and hopeful attitude toward the families showing interest in adoption.

- Adding two black social workers to the staff.

- Providing field placements for two black students of the University of North Carolina School of Social Work.

- Sending publicity material to all major newspapers in the State, including the black press.

- Furnishing spot announcements and interviews on black radio stations that feature soul music.

- Arranging interviews featuring black adoptive families for major television stations.

- Distributing posters describing the availability of adoptable black children to county fairs, personnel offices, churches, and schools.

- Distributing handouts about adoption by black leaders at churches and other meetings.

The success has been tremendous. Fifty-one placements have been made, 3 homes are under study, and 58 other homes have been approved.

We have not encountered obstacles in this effort. The confidence and support of black leaders were obtained initially by allowing for a nondefensive type of confrontation. They served as the liaison between the agency and the black community.

*Dorothy Curle
Associate Director
Children's Home Society
of North Carolina, Inc.
Greensboro, N.C.*

U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

COMMUNITY . . . protection against disease. Shirley Winston. HEW, OCD, Children's Bureau. CB Publication 56. 1971. 8 pp. 20 cents.

Discusses the importance of immunization and how the body builds defenses, and recommends an immunization schedule for children up to age 6.

DELINQUENCY PREVENTION STRATEGIES. HEW, SRS, Youth Development and Delinquency Prevention Administration. 1970. 20 pp. 20 cents.

Describes briefly a concept of delinquency prevention and offers suggestions for a preventive program.

VIEW AND SUMMARY OF A NATIONAL SURVEY OF THE PARENT-CHILD CENTER PROGRAM. Joan Costello. HEW, OCD, Bureau of Head Start and Early Childhood. 1971. Single copies free from OCD.

Analyzes the findings of a study by Irschmer Associates, Inc., of the first year of operation of Parent and Child Centers and their impact on children, families, and communities.

HEW refers to Department of Health, Education, and Welfare; **OCD**, to Office of Child Development; **PHS**, to Public Health Service; **SRS**, to Social and Rehabilitation Service.

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FAMILIES FOR BLACK CHILDREN: the search for adoptive parents. Elizabeth Herzog, Cecelia Sudia, Jane Harwood, Carol Newcomb. HEW, OCD, Children's Bureau. 1971. 79 pp. 75 cents.

Presents the findings of a survey to identify crucial elements in planning a program to increase the number of adoptive families available for black children in need of placement. (See p. 143, **CHILDREN**, July-August 1971.)

AN ANNOTATED BIBLIOGRAPHY ON CHILDREN. HEW Department Library, for the White House Conference on Children. 1970. (Reprinted 1971.) 75 pp. 70 cents. (Only available through Superintendent of Documents.)

Lists and annotates published materials related to topics of the 1970 White House Conference on Children.

DIVERTING YOUTH FROM THE CORRECTIONAL SYSTEM. HEW, SRS, Youth Development and Delinquency Prevention Administration. 1971. 82 pp. Single copies free from SRS.

Presents three articles about the juvenile justice system—a brief review of court intake procedures, an examination of the current high rate of juvenile detention, and a description of the youth services bureau concept.

THE PREMATURE BABY. Shirley Winston. HEW, OCD, Children's Bureau. CB Publication 40. Revised 1971. 9 pp. 20 cents.

Discusses questions frequently asked about prematurity—causes, preventive measures, difficulties, and care and development of the premature baby.

CHILD CARE DATA AND MATERIALS. Committee on Finance, U.S. Senate. 1971. 156 pp. 65 cents.

Contains statistics, reports, legislation, and regulations on child care.

MENTAL HEALTH CONSULTATION TO PROGRAMS FOR CHILDREN: a review of data collected from selected U.S. sites. Franklin B. McClung and Alastair A. Studden. HEW, PHS, National Clearinghouse for Mental Health Information. PHS Publication 2066. 1970. 60 pp. 65 cents.

Describes a study of programs, practices, and procedures of child mental health consultation in 18 centers at 10 sites, with recommendations for the development of new programs in training and research.

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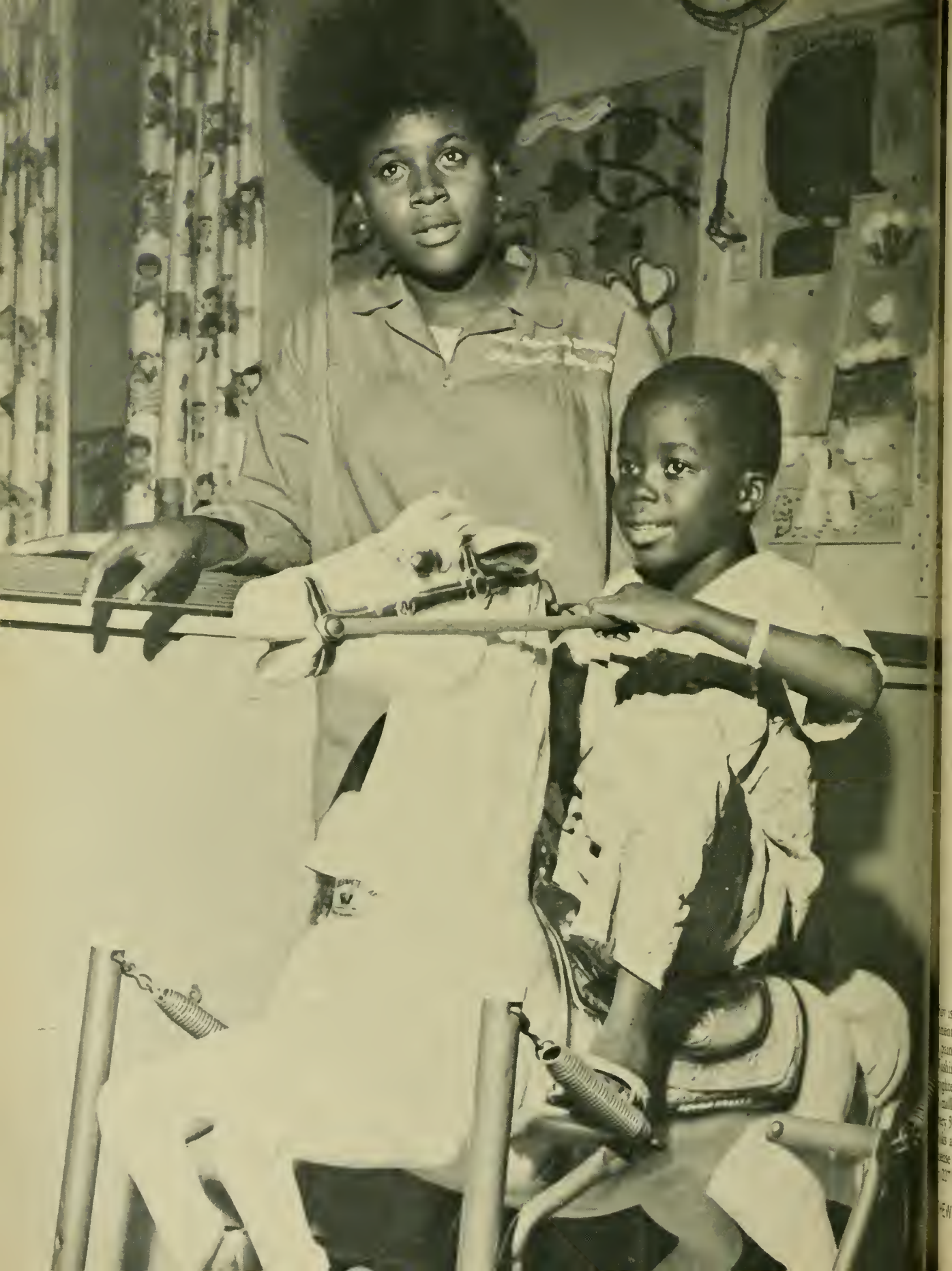
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november • december 1971
involving parents in a children's clinic
adolescent maternity services
intercountry adoptions
fighting sickle cell disease
teenagers discuss age restrictions



CHILDREN

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Play is part of the therapy program for this young patient with sickle cell anemia, as he recovers from a painful crisis episode in Freedman's Hospital, Washington, D.C. The outlook for children like him brightened in 1971 as HEW undertook a nationwide \$6 million attack on the fatal disease that affects 1 in every 500 black Americans. In this issue CHILDREN looks at recent advances in diagnosis of sickle cell disease (p. 222) and nursing care of affected children (p. 227).

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CHILDREN

Involving Parents in a Children's Clinic

Eugene Langellotto

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The activities of low-income parents of children and youth served by a comprehensive pediatric clinic in Baltimore, Md., illustrate how clients can be included in the structure of a health project when staff members listen to their ideas and encourage them to speak and act for themselves.

The project is officially called the Comprehensive Pediatric Care Center, but the families it serves usually refer to it as "the clinic" or "the Baltimore Street Clinic." It is located in a low-income area of East Baltimore that encompasses two large public housing developments. About 1,100 families with more than 3,200 children live in the area.

The pediatric clinic was established in 1968 through the coordinated efforts of the Baltimore City Health Department and the Greater Baltimore Medical Center, with Federal support through the program of comprehensive health care for children and youth. The building in which it is located also accommodates a variety of adult clinics and a day care center operated by the Baltimore City Department of Social Services. A shuttle bus plies between the building and an outlying hospital, which provides the project with backup diagnostic services and inpatient care.

The pediatric clinic employs a full-time interdisciplinary staff consisting of three pediatricians, one of whom serves as project director; three registered nurses and two nursing aides; three social service

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workers, one a professionally trained social worker with a master's degree, one an agency-trained social work assistant with a bachelor's degree, and one a high school graduate from the community who has been trained as a community health aide; a dental assistant; and five clerical workers. Three dentists who specialize in serving children are employed part-time. Part-time consultants include a psychiatrist, a psychologist, a nutritionist, and a hearing and speech specialist.

Early in the clinic's operations those of us who comprise this health team realized that to provide adequate health service we needed to learn more about how our patients live. While most professional workers subscribe to the theory that you cannot treat a patient in a vacuum, experience has shown that in a large medical institution a vacuum is often created by the health professionals themselves, who often work with far too little understanding of patients' needs and circumstances—because of the staff workload, the location of the clinic, which is often far from the patients' home neighborhoods, and other reasons. The doctor or appointment clerk, for example, may be unaware that a patient's reluctance to make or keep an appointment is due to lack of money for transportation to the clinic, the fear that a long waiting period there will mean losing a day's pay, or just because a child or his parent has no coat or shoes to wear during the trip to the clinic. Fear of the hospital or the doctor can also be an impediment to service.

Our pediatric clinic overcomes some of the disadvantages of large hospital complexes: it is small—and therefore less frightening—and it is located within walking distance for most of the patients. Nevertheless, from the first we found some of the same deterrents to service that a large medical facility experiences.

Broken appointments

In the early days more than 50 percent of the appointments we gave were not kept and few patients responded to reappointments. The social service staff members were determined to find out why. We began to learn more about the families by visiting those in which a member had missed a clinic appointment.

Our approach was to let the children's parents know about our concern for them and to encourage them to talk about what was important to them.

For example, we usually introduced ourselves in somewhat the following way: "Mrs. Black, I came to visit you today because I wondered why you missed

your child's appointment last week. I thought maybe you had some trouble—would you like to tell me about it?"

Most of the parents answered willingly. Some said that they had been unable to keep their appointments because they had no one to care for their preschool children or that the appointments were set at times when they had difficulty in getting away from home or work; others said they had been given different appointment times for each of their children, thus requiring them to make repeated visits to the clinic. Some mothers complained of long waiting periods before seeing the doctor, while others said their second appointment had been with a different doctor than the first. One woman said, "Mister, them doctors just experiment on us poor people."

The clinic's response

Getting our patients to know us was a first step in gaining their confidence. As we met the families in the neighborhood, we found that most were unaware of the health resources available to them. We also learned that their image of illness was usually one of total incapacitation. Only when one of the parents could no longer fulfill his or her daily obligations and responsibilities was he or she regarded as "sick."

For example, a worker visiting a 45-year-old mother of four children noticed that the mother walked with an obvious limp. When asked about it, the mother replied, "Honey, this old hip has been bad for years, but I feel pretty good except on rainy days."

We discovered that most families knew little about the causes, treatment, and course of various diseases. They consulted the local druggist for advice about their ailments, or relied on their collections of patent medicines for cures.

Neither the parents nor the children had previously received regular dental treatment or preventive dental care. Because they visited the dentist only when in pain, most of the adults and older children had had several teeth extracted.

Thus, we found that the families generally put a very low value on health care. With meager incomes, their first aspirations were centered on finding better living quarters and securing much needed clothing and household articles.

We also found that most of the families had cut themselves off from the community. Distrustful and suspicious of other people, they were listless and seemed to have lost the power to take initiative. Unorganized among themselves, these parents did not

interact with others in their family units either.

With a new understanding of our patients' families, we were ready to design a better plan for meeting their health needs.

First, we dealt with the problem of broken appointments by employing a neighborhood resident who had been trained as a community health aide. Her duties include visiting the families for the following purposes:

- To deliver information about their first appointment and at the same time to describe the clinic's program.

- To look for obstacles that might prevent the family from clinic attendance and, when possible, find ways to overcome them.

- To help the family keep its clinic appointments. This often means changing the time and date of the appointment on the spot, and in some instances, helping the mother take the children to the clinic.

- To seek out families known to have a sick child and encourage them to bring him to the clinic.

- To tell the social worker about family problems with which she was not able to deal.

As a result of the community health aide's efforts the clinic registered a significant reduction in broken appointments. The staff began consulting the parents about convenient times before appointments were made, and members of a family were given consecutive appointments on the same day whenever possible. Parents now keep 61 percent of their children's scheduled appointments, compared with 50 percent before the health aide began work.

Second, we took steps to acquaint the people in the community with the resources available at the pediatric clinic. Members of the clinic team spoke at community group meetings, extended invitations to parents in the area to visit our clinic, and distributed a descriptive pamphlet to every tenant in the housing developments.

Many parents complained that no day care facilities were available for their preschool children. Since the day care center in our building was unable to accommodate any more children, we asked the Department of Recreation to operate a day-recreation program for preschoolers in our clinic two mornings each week. Our request was granted. The program





Staff members of the Comprehensive Pediatric Care Center, located in a low-income area that includes two large public housing developments, were concerned about the number of patients who did not keep their appointments or return for scheduled ones. They decided to find out why—and to learn more about their patients' needs and circumstances. The rapport established can be observed as two young patients enter the clinic (above) and another is examined (left).

has given more children an opportunity to participate in supervised group activities and has given their parents some free time.

From 8 to 24 preschool children attend each session of the day-recreation program. In addition to participating in arts, crafts, and games, they visit various interesting sites in Baltimore. A trip to the zoo provided most of these children with their first glimpse of many live animals.

The Department of Recreation staff was so pleased by the success of this day-recreation program that it has expanded its regular summer camp program to include preschool children.

In May 1968, the medical director offered the parents a meeting place in the clinic where they could come evenings to discuss their mutual concerns. Leadership was provided by clinic team members and the parents were informed of the meetings through posters and personal letters of invitation.

From 18 to 31 parents met monthly with the clinic director during the first series of meetings. Parents were encouraged to state their complaints and to comment on how the clinic's services could be improved. They also heard guest speakers discuss topics of special interest.

In subsequent meetings several parents within the group began to take the initiative in doing something about their common problems. Being together and knowing that others were interested in them seemed to help these parents take action on their own.

For example, a group of mothers who participated in the meetings banded together to demand better equipment for the laundry rooms of the housing developments in which they lived. Eventually they succeeded in obtaining the improvements they wanted.

When one mother learned of the tenants' attempt to replace obsolete refrigerators in a neighboring housing development, she worked with the chairman of that group and was able to get a commitment from the city commissioner of housing to furnish new refrigerators in both areas. This success was exciting for parents who had complained that their own tenant council had "never done anything for us."

As the parents became more involved in common pursuits, several of them expressed their concern about an unprotected gas pipe that passed over a stagnant, 50-foot-wide waterway near their homes. Many children crawled upon the pipe, and one child had recently fallen from the pipe into the mud below. The parents wanted to know how to correct the situation.

With the help of the social worker, they made inquiries of the city and the gas company, but no one

would admit ownership of the pipe. After many letters and phone calls, gas company officials acknowledged responsibility for the pipe and offered to meet with the parents to discuss the situation. At the meeting the representatives of the gas company offered a choice of remedies. The parents decided that the pipe should be fenced in to stop children from crawling or playing on it, and this was done.

Parents' Club

As the parents continued to meet with the medical director and social worker, they decided to name their group the Parents' Club of the Baltimore Street Clinic, and to take steps to attract other parents to the pediatric clinic.

When summer arrived, attendance at the parents' evening meetings dropped. The parents who continued to come to the center decided to meet during the day. Since the parents had voted to change the

time, the medical director agreed—not recognizing that the new hour would further restrict attendance of the fathers and mothers who worked. The day meetings generally drew about 10 mothers, most of whom received public assistance.

The group then offered to prepare a publication that would help make the community aware of the clinic's services. The *Clinic and Community Caller*, an 8-page newsletter that also contains many photographs of neighborhood activities, became a reality in June 1969. Six parents worked with the clinic's social work staff to get the factual information and photographs and write the articles for the newsletter. A father contributed illustrations. *The Caller* appeared regularly each month for almost a year.

Then the parents were informed that the newsletter would be discontinued because the clinic budget had been cut. The parents, who had developed a sense of pride and achievement in their publication, face



Parent volunteers supervise young children in the waiting room of Baltimore's pediatric clinic, which is supplied with toys and a television set purchased with money raised at a concert held by the Parents' Club.

his crisis by deciding to raise the money themselves. They held a fund-raising concert in the community that brought in \$1,236. Impressed by the parents' priorities, the clinic administrators readjusted their budget to include money for the newsletter for the fiscal year beginning July 1970; therefore, the special funds were not needed.

It soon developed that a monthly newsletter was too much work and the parents decided to issue *The Caller* bimonthly. Since July 1970, the publication has appeared every other month. A mother serves as the editor with almost no help from the social work staff. Two parents and two children do the art work for each issue. Other parents furnish material about community activities and the clinic supplies information on health education and clinical services.

The newsletter has been a motivating force in helping the parents' group grow and in establishing the clinic more securely in the community.

One outgrowth of *The Caller* has been a series of art exhibitions of works of parents and children. The first show was held in the clinic on a Sunday. It included, in addition to oils and watercolors, items the exhibitors had created from waste materials—for example, animal figures made from egg cartons and jewelry from chicken vertebrae. Seven parents and 12 children contributed exhibits.

The experience of finding that others were interested in their creations prompted the parents to make their own arrangements for a second exhibit, which was held in a housing project. It was so successful that it promises to become an annual event.

The success of the fund-raising concert helped the members of the Parents' Club gain a great deal of recognition in their neighborhood and nearby areas. Soon parents were being asked how the money would be used. They decided to supply the pediatric waiting room in the clinic with a television set and toys, so that the children waiting to be examined could be entertained or occupied. The costs of installation and an antenna were paid for by the clinic.

It was not very long, however, before the toys were broken and had to be replaced. The parents realized they did not have enough money to continue to supply the waiting room with replacements for broken toys. Therefore, in the spring of 1971 two mothers volunteered to supervise the children's play activity in the waiting room, a duty they have continued to perform.

Recognizing their ability, a social worker arranged for the volunteer mothers to attend a Children's Television Workshop seminar where they could increase

their knowledge and skill in working with young children. This resulted in the pediatric waiting room being selected as a "Sesame Street" viewing station. Equipment used in the "Sesame Street" programs is now given to the pediatric center, thus eliminating the need to spend more money on toys.

Although the two mothers started as volunteers, the professional staff felt that they should not continue to work without pay. Therefore, the center applied for Work Incentive Program traineeships. Since August 1971 the two mothers have received a small wage from the State.

Other activities

The Parents' Club is now formally organized with elected officers. Meetings have been shifted back to evening at the request of parents and regular attendance has grown to 24.

Other activities and services have resulted from the formation of the Parents' Club. When members of the club compared the services of the pediatric clinic, which is operated for their children every weekday, with the services of the medical clinic for adults, which was then operated 1 day a week, they began to prod the adult clinic's staff to expand services. From these suggestions, a prepaid medical assistance Family Care Program was developed. Parents' Club officers appointed two members of the temporary advisory council; later the council will be elected by the people enrolled.

More than 500 people have signed up for the Family Care Program since it was launched in April 1971. This has enabled the center to increase its services to the community by hiring a full-time staff for the medical clinic, with an internist on duty 5 days a week.

The parents are also responsible for the employment of neighborhood youngsters in the pediatric clinic. In the spring of 1971, parents suggested that two students from each of the two housing projects be employed in the clinic for the summer. Along with the request came the suggestion that the Neighborhood Youth Corps pay the salaries of the students—an idea the clinic staff found most attractive. The administrators not only accepted the suggestion, but also found jobs for six students instead of four.

Now the Parents' Club has begun to operate independently, drawing on the experience its members have gained in making their own decisions. The club has also demonstrated to other parents that administrators of the pediatric center are willing to listen to the people they serve and to act on what they hear.

ADOLESCENT MATERNITY SERVICES

Eleanor W. Smith

Anne Duncan

Judith Weatherford Shouse

Richard C. Brown



A new mother brings her infant to the well baby clinic at Children's Hospital for a monthly followup visit, one of the many services provided by the Adolescent Maternity Center.

Pregnant students—married and unmarried—have been a great concern of professional health workers for some time. Not only are there greater numbers of adolescent mothers, but they are becoming more visible in all socioeconomic and racial groups. Most unmarried girls no longer conceal their pregnancies by leaving their communities, and more girls are keeping their children, regardless of marital status.

Thus, the immediate needs of the pregnant girl have ceased to be our sole concern. We are now concerned also with her future ability to mother, her maturation into womanhood, and her new function in family, community, and society. We have searched for the best ways to allow her to explore these changes in her roles for herself. Based on our experience, an interdisciplinary team approach appears to be an appropriate method of helping the young mother deal with the multiple tasks she faces.

The center setting

The Children's Hospital Adolescent Maternity Center opened in San Francisco in September 1967. It is supported by the San Francisco Unified School District, Children's Hospital of San Francisco, and occasional voluntary contributions. As an academic, medical, and social service program, it has now served about 400 pregnant young girls and their families.

The girls come from all income levels and racial and ethnic groups, and from all geographic areas of San Francisco. They come to us on referral from their doctors, their schools, and other agencies. As our Center has become better known, more girls are also referring themselves, often as soon as their pregnancy is confirmed.

About half of the girls are married when they enter our program. Nearly all keep their babies now in contrast to the 10 out of 100 girls who placed their infants for adoption during the first year of the Center's operation.

The Center program includes a school for the girl with junior and senior high school classes held in a building on the hospital grounds from 8:30 a.m. to

TEAM APPROACH

p.m. weekdays; a maternity clinic for prenatal care and post-partum followup; and a well baby clinic designed to follow mother and child for the first 2 years. In addition, the students meet with nurses, social workers, occupational therapists, dietitians and academic and vocational counselors for group discussion and individual guidance sessions.

New fathers are invited to join some of the Center talk sessions and meetings are also held for the mothers of students so they too can discuss shared beliefs and problems.

Most students continue to attend the Center school for a short period after their babies are born. While they attend classes, their infants may be cared for in a nursery that is part of the Center program.

The Center is a community where adolescent struggles with personal identity and relationships with others can be worked out with girls in their own age group and situation, where adults listen, attempt to understand what young people are saying, and support the problem-solving processes. It is a place where a young woman finds herself first observing and then involving herself with both other students and adults in the program.

Members of the Center team encourage this involvement. They allow themselves to be observed at work, to be questioned, to be challenged, to be responsive in the whole interaction between themselves and the young people. This sense of community is of vital importance in supporting the young person's development and social maturation.

Such specialized, comprehensive service is needed because the young women in our program are still in the active process of maturing on multiple levels. The tasks and responsibilities they face are great. Our program aims to help them and their families deal with the many pressures of their new—and in many instances, premature—roles as wives and mothers. We feel that this kind of help is the right kind for all school-age parents and their children.

The goals of our program are threefold:

- To offer a pregnant young woman opportunity and encouragement to develop her inner strengths,

examine her alternatives and make the best choices to meet her needs and those of her family; to help her mature; and to foster her feelings of hope for the future.

- To assure mother and child the best obstetrical care and knowledge obtainable during pregnancy and to motivate young families to continue to pursue medical care.

- To offer a young mother opportunity to continue her public school education; to encourage her to approach education as a means of self-realization; and to aid her and her family in developing future educational or vocational plans.

The interdisciplinary team

We feel that close interaction among disciplines best serves the broad needs of our young people. Our team consists of a basic core of individual professional members who are directly responsible for the educational, social, and health needs of the young families with whom they work. These three—teacher, social worker, and nurse—are responsible to the individual girls and, in turn, to a group of hospital and school district administrators who determine Adolescent Maternity Center policy.

The hospital pediatrician, obstetrician, and other staff members, of course, are also involved in the interdisciplinary team. Dr. Gilbert A. Webb, Chairman of the Department of Obstetrics and Gynecology of Children's Hospital, who was responsible for initiating the Center program at the hospital, and Mrs. Elaine Wolfe Grady, Director of Special Service Centers, San Francisco Unified School District, who originated the idea of the Center, play strong supporting roles.

Eleanor W. Smith is coordinator of the Adolescent Maternity Clinic on the staff of Children's Hospital of San Francisco and clinical instructor in nursing at the University of California, San Francisco. Anne Duncan has been the head teacher at the Center school since its inception in 1967. Judith Weatherford Shouse, a clinical social worker, also began with the Center team in 1967. Richard C. Brown, M.D., is a Youth Service pediatrician at Children's Hospital.

The core staff meets at least twice weekly, maintains daily communication with each other, and continuously consults with other members of the staff. In addition, others who work in the Center, either as professionals or volunteers, also attend a weekly staff meeting. Conferences are held following student visits to the Young Families Well Baby Clinic and the Adolescent Maternity Clinic. These involve the pediatrics and obstetrics consultants and residents, as well as nurses, social workers, dietitians, and volunteers.

To further develop a feeling of community, a weekly meeting of the student body is held. The meetings, which are also attended by core staff members, serve as a forum for sharing information and developing problem-solving and leadership qualities. Every effort is made to keep communication free and open among staff, students, and administration.

The handling of a sudden complication or tragedy affecting one of the girls in our program illustrates the team's use of open communication. Pregnant girls in our Center grow very close to each other because of their shared experiences and concerns. News spreads rapidly throughout the Center community, and rumors become distorted as they disseminate. We have found that the best way to relieve such a situation is by offering accurate information and then encouraging discussion of the facts. The team nurse is responsible for gathering all the medical facts about a situation, communicating them to members of the staff, and then to all the young people. All of the staff encourage discussion of the information and, most important, exploration of feelings.

For example, 16-year-old Jane's baby was born with twisted and deformed feet and legs. The infant was to have casts put on her legs on the second day of life. If the casts did not correct the deformity, the baby might later need surgery. The prognosis was good, but it was thought that months or even years might pass before the final correction would be completed.

The nurse talked with the obstetrician, pediatrician, and orthopedic surgeon and discussed with Jane her understanding of what she had been told and helped her to express her anxieties and fears. She then informed all members of the staff and the young women in the program. Through open discussion in groups and individually with each other, the girls became able to express their own feelings and also to understand Jane's feelings. Instead of avoiding Jane, her closest friends initiated communication with her by visits and telephone calls. When Jane returned

to school she was able to discuss her experiences and her feelings with the whole community.

We were able to share her pain and eventually her joy when, in only a few weeks, the casts successfully corrected the baby's deformity.

Pregnancy during adolescence

When pregnancy occurs, the adolescent's normal striving toward independence is distorted and disrupted. She has been struggling with her need to become an independent person, to break away from her family, while still needing its support in many ways. Because all the material and emotional needs that normally evolve during pregnancy are accompanied by a concomitant desire for independence, the young woman often suffers great anxiety and conflict.

A young girl also responds intensely to the normal physical changes which occur during her adolescent years. When pregnancy is superimposed on this already stressful phase of development, she becomes acutely sensitive to the greater alterations and distortions of her body. These uncontrollable changes of adolescence and pregnancy produce feelings of anxiety about herself as an emerging woman and mother.

While one young pregnant girl will wear a tight buttoned coat throughout the day, regardless of activity or weather, another may appear unaware of her changing figure and continue to wear clothing which no longer fits. Many pregnant adolescents do not wear maternity clothes because they "look like they are for old women" or, as one girl explained, "Those clothes just hang on you like sacks".

Mastery and control over her emotions as well as her body is another concern of the adolescent. This, too, is intensified during pregnancy. A young girl feels helpless about what is happening to her and anxious about what will be done to her. Through anticipatory guidance she may be helped to attain a sense of control over or mastery of the tasks which confront her. The processes of labor and delivery can be made comprehensible and less frightening, so that she will be able to utilize the helpful information made available to her.

When the young mother successfully meets the challenge of giving birth, when she feels that she has accomplished this adult task with dignity and self-control, she is better able to move on toward motherhood. If her own needs are met, she is usually able to become a giving mother and to achieve a relationship with her child that will be a foundation for continued healthy development.



Hopes and fears regarding parenthood are aired by young mothers and fathers as they meet with members of the hospital staff and the Adolescent Maternity Center team at Children's Hospital of San Francisco.

An adolescent girl who has rarely experienced physical pain and hospitalization may be very fearful of hospitals and health workers. Or she may have had an experience which she recalls as frightening and is now suspicious.

The only experience Gladys, now 15, had had with a hospital, for example, occurred when she was 8 years old and had broken her arm. Gladys remembers what seems to her to be long hours of waiting in an emergency room in great pain, with no one interested in helping her. Once pregnant, Gladys was so fearful of doctors and hospitals that she did not go to the clinic for her prenatal visits until her classmates convinced her that she must. The first time she visited the clinic, she could not tolerate the waiting for care and left before being seen. The social worker discussed her difficulties with her and, through role playing, helped her to formulate the questions she wanted to ask the doctor. When Gladys reached the clinic a second time her anxiety returned and she sought out the nurse, demanding that the nurse ask these questions for her. The nurse assured her that she would be present in the clinic and ready to help her, but that she was certain Gladys could ask these questions herself. Gladys again reviewed her questions and then was seen by the doctor. Thus, through the support of her peers, the social worker and the nurse, she took the final step toward feelings of trust and confidence in health services personnel, a step which will be of lifetime value to her and her family.

Another important aspect of adolescence is that of achieving success in work and learning. Here the teacher on the core team plays a major role. Many students in the Center come to us handicapped by

their lack of verbal skills. Often their previous attempts to learn or to adjust in the usual classroom setting have resulted in failure because of their feelings of inadequacy or inferiority. Pregnancy and its accompanying fears and anxieties are an additional complication. Until the anxiety is reduced, nothing meaningful can happen in the classroom. The warm acceptance of the teacher is not enough. Neither are the school's very small teacher-pupil ratios or the courses and texts that are tailored to individual students' levels of comprehension. It is the total climate, generated by all the disciplines working together and the support of her peers, that helps the individual girl to be willing to face the educational task.

In our program as much responsibility for learning as possible is given to the student herself. Within the firm ground rules and basic expectations of the teacher, the student may set her goals and thereby assume greater responsibility for her own learning, and for her success. Learning occurs more readily when the student finds personal gratification in her work, gratification derived from the attention, help, and honest praise given by the teacher and from her own mastery of meaningful work.

Another task during a girl's adolescence is the establishment of sexual identity as a woman and, in our Center, as a mother. The team facilitates this growth process from girlhood to motherhood, and appeals to the part of the developing adolescent which is striving toward maturity and adult responsibility.

A personal moral value system normally evolves during adolescence. Members of the staff are aware of this process and of their roles as models representing various value systems. For many young peo-

ple, acquaintance with staff members offers a unique opportunity to examine closely the values of adults other than their family members.

Developing a sense of the future is another feature of adolescent growth which assumes special importance at our Center. When a young woman enters our program, it is often with a deep sense of shame, guilt, failure and a pervasive feeling of helplessness and hopelessness. Her mother usually shares and confirms these feelings. Their sense of the future is in abeyance; the present defeats them both. A specific goal of the program is to help a young woman look toward the future, to develop her inner resources, and begin to feel a sense of mastery over her life. In her first interviews with the staff she is asked about her ambitions and goals. Often the reply is a helpless shrug, and, "Well, I always wanted to be a teacher, but now. . ."

As time passes, the young woman is frequently and positively confronted with a need for future planning. Choices of academic or vocational pursuits are presented by skilled counselors who suggest achievable goals and realistic plans for accomplishing them. The student aspires to and reaches academic goals, perhaps for the first time in her life. The adult achievement of bearing her child results in a sense of pride which often increases her good feelings about herself and may expand her ability to cope with future life tasks. Such achievement, reinforced by all disciplines, affirms her hopes for the future.

When Arlene, a 14-year-old girl attending the Center, described the lives of her two unwed sisters—21 and 24 years old, one with five children and one with eight, and both seemingly helpless to change their lives—she said, "It's not going to be that way for me." This was the beginning of her understanding that she had the responsibility and, more important, the ability to control her future and to direct the course of her life.

The girls view the team

The interdisciplinary team presents a choice of adults to whom the young pregnant woman can relate at various times and in various ways. When a team has demonstrated care and concern for her, she may be able to trust one or all members, or she may want to transfer her trust from one team member to another as her needs change. For example, a girl may have established a trusting relationship with her social worker, who has helped her to deal with her problems realistically. Then, as her delivery approaches, she is

overwhelmed with fears and anxieties about what this experience will entail, and by feelings that she has been unable to deal with earlier because of her many other pressing problems. At this time she may turn to the nurse for information, help and support. Later, as the young mother prepares to return to regular school and becomes most concerned with her future academic career, she may seek the help of the teacher, who is the individual most able to provide what she now needs.

Sometimes a young woman finds only one adult to whom she can relate in a trusting way. When she chooses to use the team in this manner, by relating to one individual only, the other team members can often help through communication and consultation and by provision of surrogate care and support where the trusted individual is unavailable.

The trusted team member must exchange information with other team members so she can gain a wider perspective on the total care of the young woman. An even more difficult responsibility is to use her relationship with the student in a positive way.

Acting in the capacity of the good parent, she makes every effort to give the young mother the support and security that she so desperately needs. Simultaneously, her goal must be to increase the young woman's feelings of personal worth and self-confidence, so that she may move on to trust others. In this way the student is prepared to eventually separate from the trusted person and the sheltered community of the Center. Such a core task is reminiscent of Helene Deutsch's statement that the tragedy of motherhood is that the mother must begin to separate from her child even at the moment of its birth.¹ The professional worker, just as the good mother, provides support but prepares for separation by fostering trust in others and by promoting growth and maturity.

By allowing the young woman herself to choose the way in which she will use the team, we give her real alternatives and freedom to find what is most acceptable to her to meet her own needs. At the same time that she is experiencing this independence and ability to make choices, she is supported by the knowledge that there is a team that knows her, cares about her, and upon whom she can depend.

Most important, though, for the adolescent mother is the fact that the interdisciplinary team provides an approach to the care of the whole person. A combined concern for her physical, emotional, social, educational, and occupational needs can only be provided by a group of professionals whose varied ex-

expertise is directed toward an understanding in depth of the many aspects of her needs and who can promote care for the whole spectrum of needs with sensitivity and skill.

Members view the team

When, for example, a staff conference was held to discuss similar problems of three young students in the classroom, staff members were hoping to identify the difficulties and discover interventions that could be used to resolve them. All three girls had attended school for only a few weeks and were seemingly unable to relate to the other girls and staff. Their attendance was poor and they were not participating in group work. However, a pooling of observations and information among staff members disclosed that the three young women presented differences rather than similarities—in their present family problems, in their past experiences, and in the stages of their pregnancies and the physical and emotional changes related to these stages. Such differences in the stresses that these young women were experiencing suggested very different interventions in the care of each. Without the interdisciplinary team conference and the opportunity to share information and expertise, the school's teachers would have continued to struggle with behavior which really was not related to academic stresses but to physical and emotional problems.

The interdisciplinary team approach thus affords many advantages for the pregnant young woman. Her involvement with staff and peers supports her during this stressful time in her life.

However, the time comes when she must leave the Adolescent Maternity Center, must leave the shelter of a special program, and must deal with the problems of this separation. Her process of termination is like that of any person experiencing a loss of someone or something that has been very meaningful to her. Every girl goes through the mourning process in varying degrees, reacting with anger, denial, and sorrow before reaching a resolution. Similarly, staff members react to the loss of young people with whom they have developed very close relationships. They continue to see many girls informally when they visit the school or bring their babies in for care. Even though the young mother moves on into new experiences, she often needs to return in some way to what she has left behind, to reflect on her experience and to further integrate it into her maturing self. Thus she achieves a renewal of hope and confidence for her own and her family's future.

While the interdisciplinary team approach seems to provide many advantages for the pregnant adolescent, it makes certain unusual demands on team members. Each staff person must be willing to be used by patients in ways that may differ considerably from the expectations gained from his own professional education. Although many professions give lip service to the team concept, few actually understand the changes which it produces in professional functioning and in patient-professional relationships. As Dr. Jessie Bierman wrote,

"There is much talk and some practice of what is called the multidisciplinary approach to problems these days. But just because members of several disciplines are brought together does not necessarily mean very much. They sometimes remind me of two-year-olds playing together. It is really parallel play rather than any real communication or learning from one another. Our professional schools should be teaching us to play together at least on the three and a half-year level!"²

In addition to becoming more flexible in his relationship to the patient, the member of an interdisciplinary team must understand the work of other team members and strive to reduce the stereotypes he holds of professional colleagues. Trust and confidence in each other must also exist among the team members, who should accept each other as individuals who bring differing interests, abilities and life experiences to bear on the total care of the young family.

Summary

In a rapidly changing society the health professions must find new and appropriate ways to guide those who seek help in coping with their present concerns and needs, as well as ways to prepare them for their future life tasks. In no group is this more apparent or more important than with school-age families. No single discipline can deal comprehensively with the broad spectrum of needs of the young mother and her child. Our experience with an interdisciplinary approach has convinced us of its value both to young families and to the professionals who are involved in their care.

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² Bierman, Jessie M.: Some things learned. *American Journal of Public Health*. June 1969.

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A Fresh Look at Intercountry Adoptions

John E. Adams

Hyung Bok Kim

Intercountry adoptions stimulate both enthusiastic support and vehement opposition. The proponents say the primary reason for such adoptions is direct humanitarian service to needy children and to prospective parents. The opponents argue that no child should be transplanted from his own culture, nationality, and race and asked to bear the burdens of possible rejection and loss of identity.

Even as the dispute rages, statistics show that intercountry adoption is now a well-established practice, although it had its beginning as an organized social service activity only within the past 25 years.

During this period better communication and extensive international travel have led to increased awareness of the needs of children in other countries. As a result, new attitudes of responsibility toward and acceptance of these children have developed. This new social awareness, together with the dramatic increase in intercountry adoptions in the past 3 years, suggests that the interest in such adoptions will continue to grow.



It seems to be a good time, therefore, to put the practice of intercountry adoptions into perspective.

First, such adoptions are becoming a significant part of the American child welfare scene. A comparison of the current level of intercountry adoptions by citizens of the United States—2,080 in

1969—with the current level of domestic adoptions—171,000 in 1969—shows that better than 1 adoption out of every 100 now involves a child from another country. Furthermore, the proportion of such adoptions is growing.

Second, American parents are not alone in the practice. Sim-



Europe's economic recovery following World War II, European parents have been adopting children from countries other than their own—first from Europe, then from Syria, India, South Vietnam, the Philippines, Korea, and most recently from South America. Our agency—the Holt

Adoption Program, Inc.—alone placed more than 400 children from Korea in European countries during the 1970 calendar year. While no figures are available for the total number of intercountry adoptions in Europe in 1970, we think a reasonable estimate would be more than 1,000.

We use the term "orphan" as the U.S. Immigration and Naturalization Service does—in a legal, not literal, sense. The current law contains the following definition: "... an alien child (1) who is an orphan because of the death or disappearance of both parents, or because of abandonment or desertion by, or separation or loss from, both parents, or who has only one parent due to the death or disappearance of, abandonment, or desertion by, or separation or loss from the other parent and the remaining parents is incapable of providing care for such orphan, and has in writing irrevocably released him for emigration and adoption."¹

If a child comes into the United States for adoption, the American citizens who are petitioning as adoptive parents must comply with all preadoptive requirements of the State of the child's proposed residence. If the adoption is to be completed abroad, both American parents must meet the child personally before or during the adoptive proceedings.

In either case, the Immigration and Naturalization Service requires the adoptive parents to obtain a visa for the child to be admitted to the United States. Before the visa is issued, a U.S. immigration officer makes an investigation of the child in his own country and, if the child is to be adopted in the United States, a licensed adoption agency in the United States makes an evaluation of the adoptive family.

U.S. immigration laws now permit adoption of orphan children up to and including age 13. A family may obtain up to two visas; exceptions are made when this restriction would mean separation of siblings, however.

Agencies involved in inter-

country adoptions usually place children without *known* parents. It is reasonable to assume, however, that many of the abandoned children do have living parents. Naturally, before adoption is considered, a responsible agency in the child's native country tries to follow up all leads to the identity of the parents and make sure the child is legally free for adoption.

The trends

Table 1 (this page) shows the broad trends in numbers and regions of origin of children from other countries adopted by parents in the United States since 1948.

During the 1948-1957 period, American adoption of immigrant orphans was primarily in response to an awareness of the inability of a devastated Europe to provide for its own children. Almost all children admitted to the United States for adoption between 1948 and 1953 came from Europe, more than half of them from two countries—Germany and Greece. Significant numbers of children also came from Italy and Austria. Beginning in 1953, a considerable number of Asian children began to be admitted to the United States—

particularly from Japan and Korea.

We believe that although many countries were unable to care adequately for their children during this period, participation in intercountry adoptions was determined by two factors: (1) the presence in these countries of U.S. soldiers and other citizens who were aware of and concerned about the plight of homeless children; and (2) the foreign government's ability to regulate adoptions and its willingness to permit such adoptions.

It was the Refugee Relief Act of 1953 that originally permitted American families to obtain a visa for a child adopted by proxy under the laws of another country. Passage of this law signaled a new interest in U.S. adoptions of Asian children; at the same time adoption of children from Europe continued.

From a practical standpoint, proxy adoptions were the instrument by which thousands of children successfully found their way to homes of their own in the United States. The person most involved in this chapter of U.S. immigration history was Oregon farmer Harry Holt, whose individual

efforts to bring children from Korea and Japan (and later from other countries) to adoptive families in America eventually evolved into the licensed agency that we now head. Therefore, it is appropriate to report that insofar as we can determine in retrospect, the proportion of children he placed who had serious enough adjustment problems to require removal from original adoptive homes was about the same as the proportion of children placed by the licensed adoption agencies at that time who had similar problems.

The original intent of proxy arrangements for intercountry adoptions—to provide homes for out-east children fathered by American soldiers—was quickly accepted in Korea. The proxy procedure was also applied to provide homes in the United States for many orphans of full Korean parentage and for large numbers of children from Japan, Italy, and Greece in the 1958-61 period.

An impasse soon developed between American parents determined to adopt children who were victims of the Korean war on the one hand and American and Korean child welfare agencies on

Table 1.—AVERAGE ANNUAL ADMISSIONS OF IMMIGRANT ORPHANS TO THE UNITED STATES FOR ADOPTION, BY REGION OF BIRTH AND BY PERIODS, 1948-1970

Region of birth	1948-1957		1958-1961		1962-1968		1969		1970	
	number	percent	number	percent	number	percent	number	percent	number	percent
Europe.....	561	73	963	39	676	41	549	26	587	24
Asia.....	206	27	1,436	59	916	56	1,155	56	1,349	56
North America.....	0	.....	35	2	27	2	312	15	404	17
South America.....	0	.....	3	.....	3	.....	27	1	33	1
Africa.....	2	.....	8	.....	8	.....	15	1	16	1
Australia/New Zealand.....	1	.....	2	.....	11	1	13	1	16	1
All other.....	2	.....	7	.....	4	.....	9	.....	4	.....
All countries.....	772	100	2,454	100	1,645	100	2,080	100	2,409	100

Summaries and averages by authors; figures: U.S. Immigration and Naturalization Service.

the other. In general the agencies were not ready to expand intercountry adoption service—a relatively untested procedure—particularly when regulations allowed adoptive American parents to bypass usual screening and other supportive social services. This impasse was resolved by extending the time limits of the Refugee Relief Act for 1 year to 1957.

From 1958 to 1961 the United States experienced its highest number of intercountry adoptions. On September 1, 1957, Congress renewed provisions for immigration of orphan children under visas and extended the time limits for proxy adoptions through 1961. Stimulated by this legislation, almost 11,000 intercountry adoptions were arranged during the 3-year period.

Not all proxy adoptions worked out well, however, and we are fortunate that this phase of our country's adoption practice ended in 1961.

Current legislation

From 1962 to 1968 intercountry adoptions declined under the legislation passed in 1961, which is still in effect. While there have been considerable fluctuations from year to year, this period shows no definable trends in adoptions. Therefore, we believe it constitutes a base of "normal" intercountry adoptive activity under current legislation.

Since 1969 the United States has experienced another dramatic rise in intercountry adoptions. In 1970 such adoptions almost reached the level of the proxy adoption years. (See table 1.) Preliminary figures for 1971 indicate that the increase is continuing.

Table 2 (right) gives comparative figures showing the number of orphan children admitted into

the United States in the years 1968 and 1970. The increases have come almost equally from Asia and from North America.

Korea and the Philippines provided most of the increase from Asia. Philippine-American adoptions differ from the normal non-relative pattern of intercountry adoptions, however: more than 80 percent of the Americans who applied for visas were relatives or stepparents of the Filipino children involved.

In 1968 only two immigrant orphans entered the United States from other North American countries. Two years later the number

jumped to 404. The great majority of these children—339—came from Canada, with smaller numbers from Mexico, Jamaica, and Costa Rica. Placements from Canada reflect the growing practice of ignoring State and national boundaries in placing children for whom a home cannot be found in his own community.

The Adoption Resources Exchange of North America (ARENA) is a leader in helping adoption agencies make such placements. Under the direction of the Child Welfare League of America, ARENA maintains a current register of the names of

Table 2.—IMMIGRANT ORPHANS ADMITTED TO THE UNITED STATES IN 1968 AND 1970: A COMPARISON BY REGION OF ORIGIN AND TYPE OF ADOPTION

[Only countries with significant increases shown individually]

Region of birth	1968			1970		
	Total	Adopted Abroad	To be Adopted in U.S.	Total	Adopted Abroad	To be Adopted in U.S.
All countries	1,612	750	862	2,409	981	1,428
Europe	630	393	237	587	356	231
Asia	953	337	616	1,349	365	984
Korea.....	515	147	368	845	155	690
Philippines.....	98	18	80	141	14	127
Vietnam.....	67	2	65	89	11	78
Other.....	273	170	103	274	185	89
North America	2	1	1	404	199	205
Canada.....	0	0	0	339	151	188
Mexico.....	0	0	0	21	21	0
Jamaica.....	0	0	0	14	4	10
Costa Rica.....	0	0	0	9	9	0
Other.....	0	0	0	21	14	7
South America	1	0	1	33	29	4
Colombia.....	0	0	0	13	12	1
Other.....	0	0	0	20	17	3
Africa	10	4	6	16	15	1
Ethiopia.....	0	0	0	9	9	0
Other.....	0	0	0	7	6	1
Australia/New Zealand	13	12	1	16	14	2
All other	3	3	0	4	3	1

Source: U.S. Immigration and Naturalization Service.

Reaching across barriers of race, culture, and national boundaries . . .

a chance for homeless children to belong to a real family.

children who are waiting to be adopted and the names of agency-approved families who are waiting to adopt a child.

The increase in intercountry adoptions of the past 2 years is not a response to an emergency in any one foreign country or region. On the contrary, the number of countries from which the children have come suggests that the reason for the increase is to be found in the United States. The 1968-70 period coincides with a period of increased interest in American-born children of minority races without homes for whom transracial adoptions have been suggested. With the developing shortage of "adoptable" white infants in the United States, American parents are beginning to look overseas for children. Therefore, we believe that intercountry adoptions have now become a permanent part of the American adoption scene.

Service to the child

On the positive side, there is no question that intercountry adoption offers many homeless children of the world their only chance to belong to a real family. The value of intercountry adoption is supported by a growing body of evidence that shows adoption is demonstrably better than institutional life, and that adoption is generally as viable for the child as entry into a home by biological birth.²⁻⁹

In the emerging countries the

new patterns of industrialization break down the extended family system. Yet in the transitional stage, the very mores of blood ties that formerly protected the child now prevent him from being adopted into another home. In other words, the custom of nonrelated adoption is not yet acceptable. Social services are always in short supply, and support for dependent children, relinquishment counseling, and foster homes are non-existent.

Children unfortunate enough to lose their parents and extended family during this stage of national development end up on the streets or in orphanages. In either case, mortality rates are high.

Abandonment of children frequently becomes a problem in developing countries. For example, Korea has had severe problems of abandonment and institutionalization of children since the Korean war. The Korean government has encouraged intercountry adoptions through American and European agencies as part of the answer for children without families. The visibility of intercountry adoptions has impressed Korean adoption agencies, the government, and the people alike with the potential value of intracountry adoption as a preferable alternative to placement in orphanages.

At the beginning of this period, nonrelative adoptions by Koreans were almost unknown. Today such adoptions are gaining popularity.

Furthermore, they are being arranged by a growing body of Korean social workers who have become proficient in adoption casework.

Research

Research is needed to evaluate the long-term success of intercountry placements. For more than 20 years, hundreds of children from both European and oriental cultures have been involved in the transfer to homes in other countries. The experience is there; we only lack systematic study for some definitive answers. Placements from Asia that involve not only transcultural but also transracial adjustments are of primary interest now. Their study may provide some clues to guide us in the current effort to meet the needs of American-born children of minority races through transracial adoptions.¹⁰

Followup studies of transracial and transcultural adoption which are still fairly rare, usually comprise reviews of the first few years after placement. Most of these followup studies¹¹⁻¹⁵ as well as a symposium held on the subject^{16, 17} suggest favorable results. For example, during the 1960s David Fanshel studied American Indian children adopted by white families, a practice with many cultural and psychological parallels to intercountry adoption. He found the children are doing "quite well."¹⁸

A study of placements of Korean children who are now 13 years of age or older and who have been in their homes for 5 to 15 years is underway at the University of Oregon. Preliminary indications are that the great majority of the adolescents and young adults are making satisfactory long-term adjustments.

Problems of adjustment

Although further study of long-term adjustment of intercountry adoptions is needed, we can make some subjective judgments based on our experience. Infants traveling to the United States from abroad usually experience temporary confusion from the trip, but face few cultural or language adjustments. Preschool children face many adjustments in culture and language, but the great majority appear to pass through this transition with no enduring problems.

The adjustment problems with which children and adopting families will need to cope and for which they may need supportive social services appear to increase in somewhat linear fashion as the child's age at placement increases. Adoption during the years of puberty and the teens is the most difficult. Yet—perhaps somewhat surprisingly—a number of families report successful adjustments of children adopted even during and following puberty. Key factors are the attitudes and adaptability of the teenagers and the resourcefulness and experience of the parents. Agency support during the pre- and post-placement periods is vital for older children as well as for their adopted families.

Identity problems are sometimes heightened by the excessive attention that a family or a community pays to a child of a dif-

ferent race or nationality. At least for oriental children, this seems to be a greater danger than the commonly discussed one of racial rejection. Our impression is that in a supportive home the problem of identity is no different for adopted Asian children than for children of American businessmen or missionaries returning to the States after living abroad. Furthermore, the issue of identity for the immigrant child in the United States must be balanced against the alternative problems of identity and self-worth within an institution in the country of his birth.

Benefits and risks to the family

The motivations of families undertaking an intercountry adoption seem to be undergoing change. Initially such adoptions represented a concern for displaced children following the devastation of a world war. Today parents interested in intercountry adoptions show a more general awareness of the problems of children throughout the world and a concern about overpopulation.

Although some families turn to intercountry adoption when unable to adopt a child in their own community or State, many others make intercountry adoption their first choice. By intercountry adoption they seek to experience a common humanity across the somewhat artificial, yet frequently painful, barriers of race, culture, and national boundaries. Such motivations may reflect healthy humanitarianism or they may have some basis in feelings of guilt. Likewise the motivation for adopting a GI child of part-American parentage may be based on guilt, on racial prejudice, or on racial openness.

The adopting family, with help from the child welfare agency,

must work through these feelings to discover its true motivation for seeking the child.

As long as the drive to have and to raise children continues, adoption will benefit participating families—particularly those in which the parents are unable to have children biologically—as well as the children themselves. All adoptions provide an opportunity for a parent-child relationship that may be second only to marriage in terms of human intimacy.

The risks for the family in an intercountry adoption are inherently the same as those in an adoption of a child from the community or State. Early deprivation in many cases retards the child's physical and mental development. Although the physical recovery of the child in an adopted home can be dramatic and gratifying, the long-range mental effects are not as easy to assess. However, there is now reason to believe that the effects of early deprivation are more easily reversible than we once thought.¹⁹

In our experience, children who have survived particularly grim circumstances frequently show unusual strengths and drives that lead them to excel after adoption. It is important, therefore, that adoptive families be positive in their acceptance of the child and flexible in their expectations of academic, social, and athletic achievements.

Medical and social services for a homeless child in a developing country do not equal those available to adoptive parents in a developed country. Thus, the incidence of arrested tuberculosis and infections in children from other countries is higher than in American-born adopted children. The problems of communication

occasionally prevent the discovery of a health problem until the child arrives in the United States.

The role of the agency

American adoption agencies have played a significant role in the increase in intercountry adoptions since 1968. Figures from the Immigration and Naturalization Service given in table 2 include a breakdown between the children adopted abroad by American citizens and then brought back to this country, and the children for whom adoption will be completed after their admission into the United States under a visa obtained by citizens who have met preadoption requirements through an agency in the United States. With minor exceptions, therefore, the column marked "to be adopted in U.S." indicates the involvement of U.S. adoption agencies. From 1968 to 1970 intercountry placements by U.S. agencies increased 65 percent while overseas adoptions increased 31 percent.

The placing of a child through intercountry adoption represents a considered judgment on the part of the agency that an adoptive home will serve the best interests of the child and is preferable to the other options available to that child. When such a judgment is made, the adoption agency must be willing to take some calculated risks in behalf of the child and his family.

Since both the child and the family assume additional risks and adjustments in intercountry adoption not present in intracountry adoption, the normal screening, counseling, and supportive roles of the adoption agency are particularly important. The family can be helped immeasurably

by an explanation and interpretation of the circumstances out of which the child came and by a joint exploration with the agency staff of each member's own attitudes, expectations, and resources.

Once the decision to place a child with a specific family has been made, the adoption agency should assume the role of expeditor. While regulations governing intercountry adoptions provide valuable safeguards for the child, they can add up to time-consuming formalities. Therefore, an American adoption agency can perform a real service by assisting the family in preparing the necessary supporting documents and in avoiding other unnecessary delays.

American social agencies need to verify the fact that the adoptive family does indeed have adequate resources. The corresponding agency overseas wants assurance that the child is entering an adequate family and will receive full legal adoption, including inheritance rights, legal rights, and citizenship. Some countries have a form of "adoption" that omits one or more of these elements. Some other countries have a practice of "adoption" that really constitutes a labor contract: a middle- or upper-class family "adopts" a girl from a poor family and promises to educate her to some degree while in return she becomes a concubine or housekeeper-child nurse.

A major problem in intercountry adoptions is the lack of compatibility between legal systems of different nations. The area of adoptive law appears to be the slowest to respond to the changing concepts of child welfare needs. Some major developing countries do not even have a basic child welfare law.

Agencies involved in intercountry

adoptions have an opportunity to urge upon governments reforms that may be needed in laws and procedures. For instance, a number of developing countries quite understandably insist on a completed legal adoption under their own laws before permitting a child to leave to join parents in another country, in the belief that this is the most concrete protection they can offer the child. We believe the advantages of a trial placement and the reliance on responsible adoption agencies for support as alternatives to the present procedures should be advocated by agencies dealing with authorities in these countries.

An adoption agency can accomplish a great deal through public education. Many parents' groups have organized recently in the United States with the express purpose of facilitating adoptions. The interest of such groups can be utilized to publicize the needs of homeless children in the United States and abroad, to encourage an interest in assisting all children by the best means available, and to support progressive child welfare legislation.

Agency staff members must work through their own philosophy and the motivations of adopting parents to be certain that intercountry placements are made on the basis of humanitarian service to the child and the family. Economic reasons are a poor basis of motivation because they imply a rejection of the child's cultural heritage.

We believe in encouraging parents to study the culture from which their adoptive child comes and so impart to him a pride in the country of his birth. It is healthy to recognize the reality of differences in race, nationality and culture, just as it is healthy to

recognize that parenting by adoption is different from parenting by birth.^{20, 21}

World view

The world child welfare situation as well as the practice of intercountry adoptions would be strengthened immeasurably by bringing some uniformity and modernization to adoption laws throughout the world. The European Convention on Adoption of Children in 1967 has had a beneficial influence on the updating of European adoption laws. The World Congress on Adoption and Foster Placement in Milan, Italy, in September 1971 petitioned the United Nations to convene an international conference for the purpose of establishing a World Convention on Adoption Law.

Intercountry adoption is a difficult concept for a developing country. The country gives an implicit acknowledgment in allowing such adoptions that it is not able to care adequately for its homeless children. The situation represents a reversal of the usual course of giving from the developed to the underdeveloped country. The

underdeveloped country gives its children—its most valuable possession—to the developed country. The process demands sensitivity, mutual respect, and a high level of trust on the part of the responsible people in each country.

There is a danger that intercountry adoption, which concentrates a lot of money and assistance on a few children who are taken out of the country of their birth, will become a substitute for material aid, improved nutrition, better education, and the whole range of family services needed for large numbers of children within a developing country. Our experience in Korea, however, suggests the reverse to be true: intercountry adoptions have stimulated local services to children.

The personal interest that adoptive parents take in their child's

background and heritage often leads to a personal interest in and support of voluntary work in the developing country and, as a corollary, increased public support for assistance by private and governmental agencies.

We believe the practice of intercountry adoption in the United States has come of age. The broad participation of American adoption agencies opens up the possibility of an exciting new humanitarian people-to-people social service and mutual social development through the practice of intercountry adoptions.

The ultimate goal should not be limited to helping the few children who may benefit directly from intercountry adoption, but should be to encompass the welfare of every child in the world who needs service.

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PROGRESS IN EARLY DIAGNOSIS OF SICKLE CELL DISEASE

Howard A. Pearson

In his health message to Congress on February 18, 1971, President Richard Nixon called for the allocation of \$6 million for research and treatment of sickle cell anemia. Doubtless his statement was the first time that many Americans had heard the name of the severe and incapacitating blood disease that affects about one in every 500 black babies born in the United States each year. Even within the black communities of this country, there has been little dissemination of information about this condition and its hereditary aspects.

Sickle cell anemia was first recognized in Chicago 60 years ago by a physician named James Herrick. During an examination of the blood of a young West Indian student, the doctor observed many red blood cells that were elongated and pointed instead of round. Dr. Herrick compared these abnormal forms to the blade of a sickle, and coined the term "sickle cell anemia" to describe the disease.¹

In the ensuing years a characteristic picture of sickle cell anemia has developed. It is an inherited disease that affects black people almost exclusively. Accompanied by severe anemia and by recurrent painful episodes called "crises," the disease markedly reduces life expectancy. It is unusual for a person with the disease to live beyond the third decade, and indeed many die during infancy and childhood. Estimates indicate that as many as 25,000 black people in the United States may have sickle cell anemia; thus the disease occurs at least as frequently as such highly publicized scourges of children as muscular dystrophy and hemophilia and more frequently than phenylketonuria (PKU).

Since sickle cell anemia is not curable, early recog-

nition of the disease is vital to proper management of the affected child. Reliable techniques have recently been developed for diagnosing the disease in newborn babies. When parents are told about a diagnosis of sickle cell anemia in a very young child, they can try to avoid many conditions that may lead to crises and make sure that the child obtains medical attention as soon as symptoms or severe complications appear.

Other new diagnostic techniques permit the screening of large populations of blacks to identify persons who do not have the disease but who may be at genetic risk.

Basis of the disease

Normal blood cells get their red color from hemoglobin, an iron-containing protein that transports oxygen from the lungs to the tissues of the body. Most people have a type called adult hemoglobin, or hemoglobin A. In contrast, virtually all of the hemoglobin in the red cells of persons with sickle cell anemia is an abnormal type called sickle hemoglobin or hemoglobin S.

The chemical difference between hemoglobin A and hemoglobin S was first demonstrated by Linus Pauling and his associates in 1949. Because an abnormal type of protein molecule was involved, Pauling designated sickle cell anemia as a "molecular disease."²

Many other hemoglobin types have also been detected. Fetuses and young babies have a type known as fetal hemoglobin, or hemoglobin F. Hemoglobin C occurs in about 3 percent of the black population of the United States and hemoglobin E is prevalent in Southern Asia.

When hemoglobin S is deprived of oxygen, it forms elongated, pointed crystals. The sickled red blood cell is a manifestation of this crystallization, is visible through a microscope. (See photomicrograph p. 223.) In a person with sickle cell anemia, sickled red cells often form spontaneously during venous circulation when the red blood cells give up oxygen to the tissues. The body acts quickly to remove these

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abnormal sickled cells from the bloodstream, and a severe degree of anemia ensues. In addition, the pointed elongated cells may obstruct the flow of blood through small blood vessels, resulting in the damage or death of tissues. This tissue damage is the basis of the sickle cell crises.

Blood vessels in virtually every organ and tissue of the body may be involved by this kind of obstructive process; symptoms during crises vary according to the location of the blocked blood vessel. In infancy the hands and feet are often involved, producing painful swelling (hand-foot syndrome). In later life the arms, legs, and abdomen are frequently affected, causing pain that may be incapacitatingly severe. Strokes and blindness result from involvement of the vessels of the brain and eye. Obstruction of vessels in the lung brings episodes of severe chest pain and difficulty in breathing. Because of the many symptoms associated with the disease, sickle cell anemia has been described as a "great imitator."

At present, there is no cure for sickle cell anemia

or even a completely satisfactory treatment for its crises. Because crises may be precipitated by dehydration or infection, good health management calls for anticipating these conditions and preventing them when possible; when crises develop, they should be treated vigorously.

During severe crises the patient frequently must be hospitalized for intravenous fluid therapy and relief of pain. Blood transfusions are occasionally used for severe anemia, but the value is only temporary.

A large number of drugs and treatments have been proposed over the years. However, most have been found to be ineffective when subjected to controlled clinical trials. Recently a great deal of attention has been given to preliminary reports of possible beneficial effects of intravenous infusions of large doses of urea for the sickle cell crisis, but this treatment is still experimental. Risks are associated with the infusion of large amounts of urea, so it is not recommended for small children.

Genetics

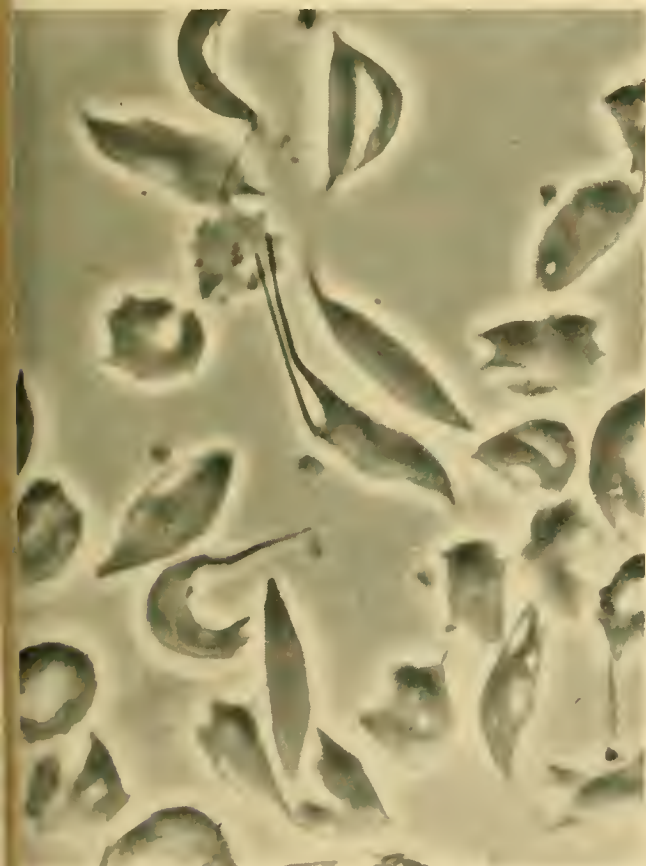
The production of hemoglobin is a genetically determined, inherited mechanism. Every person possesses a pair of genes that govern the synthesis of hemoglobin. One gene is inherited from each parent.

When both parents transmit the normal gene that results in the presence of hemoglobin A in the red cells, the child does not have sickle cell anemia.

The production of hemoglobin S is governed by an abnormal, mutant gene. When each parent gives the child one abnormal gene, virtually all the hemoglobin within his red cells is hemoglobin S. The child thus inherits sickle cell anemia. The person with sickle cell anemia also passes the sickle cell gene to his children. However, because fertility is often impaired in this disease and because of a short life span, many victims do not have children.

Some people—including the parents of children with sickle cell anemia—have red cells that contain a mixture of hemoglobin A and hemoglobin S. Because they have one gene for hemoglobin S and one gene for hemoglobin A, such people are said to have sickle cell trait. This trait occurs in 6 to 8 percent of black people in the United States.

In a person with sickle cell trait, 35 to 40 percent of hemoglobin in the red blood cells is the abnormal hemoglobin S. Spontaneous sickling does not occur in the circulation because the red cells contain enough normal hemoglobin A to counteract the effects of the hemoglobin S. There is no disease or anemia associated with sickle cell trait, and the trait does not



Contrasting with the roundness of normal cells are the pointed, elongated shapes of the red blood cells shown in this photomicrograph, which has been magnified about 1,000 times. The malformed cells are characteristic of sickle cell anemia, an inherited blood disease.

affect life expectancy or fertility. In fact, an affected person probably never knows that he has the sickle cell trait and is a carrier of the sickle gene unless special blood tests are conducted.

Medical reports have described abnormal symptoms in a few persons with sickle cell trait. Most of these incidents have been associated with a marked reduction of oxygen. For example, a few persons with sickle cell trait have experienced abdominal pain when flying in unpressurized airplanes at high altitudes as a result of sickling in their spleens. However, modern air travel imposes no hazard for the person with sickle cell trait. At the present time there is no evidence that the person with sickle cell trait must modify his ordinary life style in any special way. It should be emphasized that the person with sickle cell trait should consider himself normal.

The reason that sickle cell anemia and sickle cell trait are particularly prevalent in the black race may be explained briefly. The sickle gene is believed to have arisen by spontaneous mutation thousands of years ago in equatorial Africa. It has been convincingly demonstrated that the person with sickle cell trait has an enhanced resistance to infection by the malaria parasite.³ This resistance markedly increases survival in malarious areas, resulting in natural selection for persons with sickle cell trait. In some parts of Western Africa where malaria is endemic, the sickle cell trait is found in 40 percent of the population. In the United States and other areas where malaria has been eradicated, sickle cell trait is no longer an advantage.

The distribution of the sickle gene outside of Africa to other parts of the world can be largely explained by the slave trade during the 16th to the 18th centuries. Nevertheless, the gene is not restricted to those of African ancestry. A small number of persons of Italian, Greek, near Eastern, and Indian descent have also been found to have typical sickle cell trait.

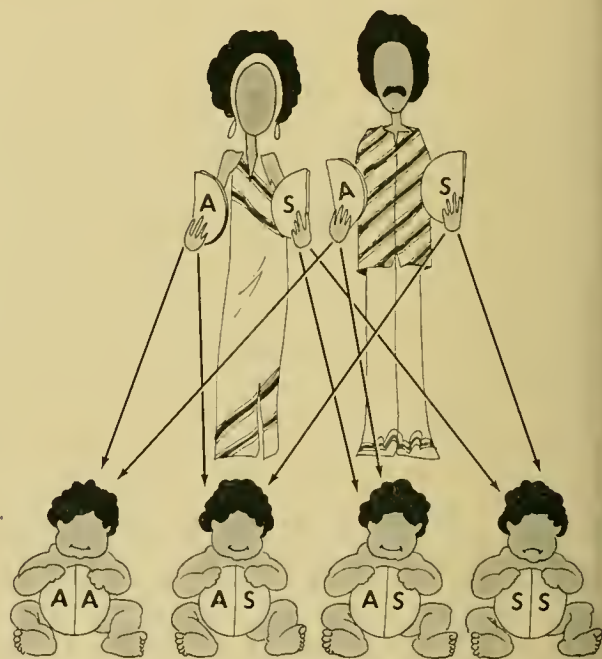
Another molecular disease, hemoglobin S-C disease, is also the result of abnormal hemoglobin. Although hemoglobin C is almost half as frequent as hemoglobin S in blacks, the person with hemoglobin C trait seldom knows of his condition because he has absolutely no symptoms. When a person inherits a gene for both hemoglobin C and hemoglobin S, he develops hemoglobin S-C disease. This condition resembles sickle cell anemia, but is usually not as severe.

Sickle cell trait and sickle cell anemia—collectively known as sickle cell disease—can be diagnosed by several methods. A number of screening tests detect the

presence of hemoglobin S within red cells. Such tests require only small amounts of blood that can be obtained from a finger stick, so they are practical for population surveys. One screening test, the sickle cell preparation, has been widely used in the past.⁴ In this test, blood cells are exposed to a chemical reducing agent. When the red cells being tested contain hemoglobin S, they assume a crescent or sickle shape that can be observed under the microscope. This test is inexpensive, but it has a significant number of false negative results.

A second screening procedure is called the Sick-

HOW PARENTS TRANSMIT SICKLE CELL DISEASE



Parents who are carriers of the sickle cell trait do not show symptoms of the disease because hemoglobin A (the normal form of hemoglobin) in their red blood cells protects them from hemoglobin S (the sickling form). But when two carriers become parents, the possibilities are:

- ☐ One child in four will inherit all normal hemoglobin (AA) and thus be free of the disease.
- ☐ Two children in four will inherit both hemoglobin A and hemoglobin S (AS) and thus become carriers of the trait like their parents.
- ☐ One child in four will inherit all sickling hemoglobin (SS) and thus become a victim of sickle cell anemia.

dex test.⁵ In this test, a small amount of blood is introduced into a solution of buffered salt containing a chemical reducing agent. When the red cells being tested contain hemoglobin S, the solution becomes cloudy; when only hemoglobin A is present, the solution remains clear. The Sickledex test is simple and fast, and it can be performed by health aides and volunteers who do not have technical training. However, it is relatively expensive.

The utility of the Sickledex test under field conditions was recently demonstrated by a screening program in the Hartford, Conn., public schools. A total of 3,456 students were tested, and the blood of 301 of these children was found to be positive for hemoglobin S.⁶

A major disadvantage of these screening tests is that they do not distinguish precisely between persons with sickle cell trait and sickle cell anemia. Therefore, more definitive confirmation is necessary for persons with positive tests. In addition, these screening tests do not detect other abnormal hemoglobins that occur in the black population with important genetic implications.

Specific diagnostic tests for abnormal hemoglobins employ a technique called hemoglobin electrophoresis. In this method, a small amount of hemoglobin prepared from red cells is subjected to an electrical current on a medium such as filter paper or gel. Under these conditions hemoglobin, which has a negative electric charge, is attracted toward the positive pole of the current. Because hemoglobin S has a slightly different charge from hemoglobin A, the two hemoglobins separate from each other.

A disadvantage of hemoglobin electrophoresis has been that the analysis requires a relatively large amount of blood, which must be drawn from a vein. In the past the procedure itself has been complicated and expensive, and has required services of a medical technologist. These disadvantages have been largely overcome by a technique recently devised by Dr. Marshall Barnes at the Yale-New Haven Hospital.⁷ Using cellulose acetate strips for hemoglobin electrophoresis, this technique requires only a small amount of blood. It is reliable and accurate, takes only 30 minutes to complete, and costs about 5 cents per test for materials.

In a recent sickle cell screening program in New London, Conn., we used cellulose acetate strips in analyzing the blood of nearly 700 children. One technologist in our laboratories made 150 hemoglobin electrophoresis assays in 8 hours, showing that this technique can be used to study large populations.

I believe that the development of such definitive, reliable, and utilitarian electrophoretic methods has virtually obviated the need for less reliable and less specific screening methods, such as the Sickledex and the sickle cell preparation tests.

Sickle cell anemia in infancy

Although the disease is inherited, the affected baby shows no signs of sickle cell anemia at birth. This is because all fetuses and young infants have fetal hemoglobin (Hgb F), a type that does not cause the disease. During the months after birth, the hemoglobin F in the affected child's red cells is gradually replaced by hemoglobin S. As the proportion of hemoglobin S increases, the symptoms of anemia appear—usually when the baby is between 6 months and 1 year of age.

There is a particular urgency for early recognition of sickle cell anemia, for the first indication of the disease in an infant may be sudden death from severe infection or anemia. Diagnosis of sickle cell anemia in an infant is technically difficult however, because of the large amount of hemoglobin F in the red cells in the first 6 to 8 months of life. During this time the sickle cell preparation and Sickledex tests are usually negative, and usual methods of electrophoresis are often inconclusive.

At the Yale University School of Medicine, we have been able to diagnose cases of both sickle cell anemia and sickle cell trait at birth by using electrophoresis on a medium of agar gel. The agar gel method makes it possible to clearly distinguish the normal newborn infant from one with sickle cell anemia or sickle cell trait.⁸

Based on this test, we have instituted a program for early detection of sickle cell anemia at Yale-New Haven Hospital. Every pregnant black woman has a hemoglobin electrophoresis performed as part of her prenatal laboratory examination. Since the mother must have sickle cell trait to have a child with sickle cell anemia, blood from the umbilical cord is collected for testing only from infants born of such mothers. After tests are completed, it is possible either to reassure families that there is no problem or to diagnose the disease and alert them to seek medical attention at the first sign of serious anemia or infection.

Need for screening

Children with sickle cell anemia almost always develop symptoms in the first 2 years of life. In localities with good health facilities most cases of sickle

cell anemia are detected by the time affected children are 3 or 4 years old. For example, in an extensive survey of more than 6,000 children 4 to 17 years of age in North Florida several years ago, I did not identify a single previously unrecognized case of sickle cell anemia.

I believe the major rationale for screening procedures after infancy is to identify individuals with sickle cell trait. About one in 12 black persons in the United States has sickle cell trait. Therefore, in approximately one out of every 144 marriages, both partners will have sickle cell trait. On the average, one in four children born of such marriages will have sickle cell anemia. The illustration on page 224 shows the genetic probabilities.

Because there is no cure for sickle cell anemia, prevention offers the only method currently available to avoid the problems inherent in having a child with the disease. In my opinion the major aim of screening programs is to identify persons with sickle cell trait so that they can be informed about the genetic implications. Each carrier should know that if he marries another person with sickle cell trait, their children may have sickle cell anemia.

Screening programs must incorporate meaningful education about the nature of sickle cell anemia and its mode of inheritance, as well as individual counseling. Information about sickle cell disease could be easily introduced into the science and biology curricula of the schools. Certainly sickle cell anemia and trait offer a more relevant illustration of genetic principles than fruit flies or peas!

The ideal timing for testing programs has not been determined. If the aim of testing is to provide carriers of the sickle cell trait with information applicable to marriage, testing in infancy or early childhood may be too early. The teens would seem to be a particularly advantageous age. A junior or senior high school student is usually receptive to a sickle cell educational program when he learns the results may have personal relevance; he also is accessible for testing and counseling. A number of programs designed for teenagers have been well received.

Study of hemoglobin could be incorporated in the premarital blood test, but by this time the results would probably be too late to affect the couple's decision to marry.

It is my belief that the purpose of testing programs is to provide individuals and couples who carry the sickle trait with the information they need to make personal decisions about marriage and childbearing. Most people would not knowingly bring a

child into the world with a painful and incurable disease that has major emotional and financial burdens.

Only by widespread implementation of programs of testing and education can the people at risk be given the information they need for informed decisions. Time will tell whether this approach has validity or merit.

Future prospects

Despite development of detailed and sophisticated information about the genetic basis and molecular biology of sickle cell anemia, the treatment of the affected child himself is still imperfect. It is necessarily directed to alleviating pain and symptoms, not to curing the disease. Nevertheless, experienced physicians trained in pediatrics and hematology can do much to help these children by skillful management of crises and anticipation of complications. Regional centers for the treatment of and research on sickle cell anemia would doubtless improve clinical care and prognosis. A painstaking search for chemicals and drugs to inhibit the sickling process within red cells should be continued.

For the future I believe that the most promising experimental possibility for the cure of sickle cell anemia resides in the area of bone marrow transplantation. Since anemia, organ dysfunction, and crises are all a consequence of spontaneous sickling of red cells in the circulation, transplantation of normal bone marrow and the subsequent production of normal red cells should reverse all aspects of the disease. Although bone marrow transplantation is not possible today, basic research into the immunologic problems of tissue typing and compatibility and the principles of organ transplantation and immune rejection may some day enable this terrible disease to be cured.

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³ Motulsky, A. G.: Hereditary red cell traits and malaria. *American Journal of Tropical Medicine and Hygiene*, January 1964, supplement part 2.

⁴ Daland, G. A.; Castle, W. B.: A simple and rapid method for demonstrating sickling of the red blood cells. The use of reducing agent. *Journal of Laboratory and Clinical Medicine*, September 1948.

⁵ Ballard, M. S.; Radcliff, E.; Sakhadeo, S.; Schorr, J. B.: A new diagnostic test for hemoglobin S. *Journal of Pediatrics*, January 1970.

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⁸ Pearson, H. A.: Hemoglobin synthesis in the fetus and newborn: diagnosis of congenital disturbances of hemoglobin metabolism. In *The clinical pathology of infancy*. Sunderman, F. W., and Sunderman, F. W., Jr., editors. Charles C Thomas, Springfield, Ill. 1967.

Caring for Children With Sick Cell Anemia

Camille L. Duckett

Throughout his life the child with sickle cell anemia faces the possibility of sudden painful crisis episodes that may keep him in the hospital or away from his normal activities for days. In caring for a child in a sickle cell crisis, the focus of the pediatric health team is on the child and his family.

There is as yet no cure and no magic formula for treatment of this wasteful disease of black children. But there are specific approaches to the crises and problems that can be individualized according to the needs of each child, his family, and the setting involved.

Black families have been largely alone in their struggles against sickle cell anemia, an inherited disease with chronic aspects.¹ Although estimates suggest the disease affects 1 in 500 black Americans, no actual survey has been made to accurately define the incidence of sickle cell anemia in the black population. There has been no mobilization of finances, research, and other resources against sickle cell anemia comparable to the nationwide campaigns against phenylketonuria (PKU) and cystic fibrosis. Yet the latter diseases of whites do not affect as large a segment of the population as sickle cell disease—PKU occurring in 1 of 10,000 live white births and cystic fibrosis in 1 of 1,000 to 2,000 live white births.²

Fortunately Federal funds have recently been earmarked to support research and to expand the efforts to find a cure. Some support will also go to providing service, which must not be overlooked as part of the sickle cell disease picture.

Furthermore, black health professionals and the black community as a whole must be included from the beginning in all planning, research, administration, and service activities related to the disease, since they are directly affected by such programs.

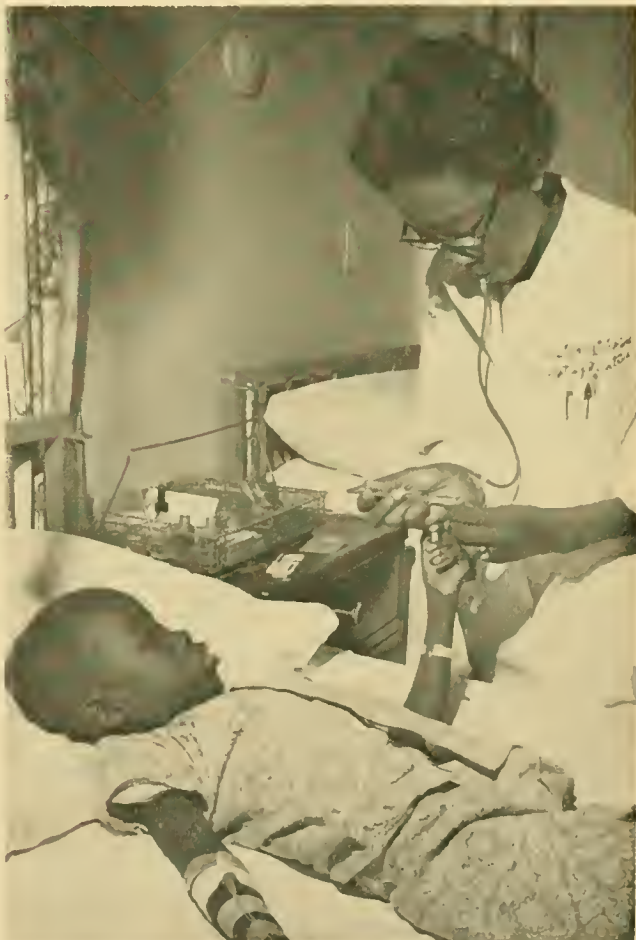
The nurse

As the health professional who is responsible for daily care of the child with sickle cell anemia, the hospital staff nurse has a crucial role to play as a member of the pediatric health team. In examining the nurse's work as it applies to sickle cell anemia, I have drawn on my experience in the Department of

Nursing Service and the Department of Pediatrics at Howard University-Freedman's Hospital in Washington, D.C., for a general guide.

I do not intend to imply that the Department of Pediatrics at Freedman's Hospital institutes comprehensive care for every young patient. The workload, environment, and makeup of the comprehensive multidisciplinary team affect the implementation of care for the patient and the interaction of professional and subprofessional health workers.

However, I believe the approaches used at Freedman's Hospital can be as useful to the nurse serving in a physician's office, home, community health



A technician takes blood from a child with sickle cell anemia, a process that is repeated many times during crisis episodes.

agency, and public or parochial school as in the hospital.

The major functions of the hospital staff nurse in relation to sickle cell anemia lie in the following areas:

1. Anticipatory guidance.
2. Coordination and continuity of patient and family care.
3. Health education and casefinding.

Although I see these as major functions in caring for a child with sickle cell anemia, I believe they may also apply to children with other chronic illnesses.

By "anticipatory guidance" I mean the process by which the staff nurse anticipates for parents and interprets to parents the kinds of behavior that can be expected of children with sickle cell anemia at various ages and at various times of stress.³

Feelings about the disease

In trying to reach the child and his family, the nurse must first assess the way parents feel about the child's illness. Her impressions of the child's and the parents' reactions to sickle cell disease may change as she meets the family in different settings—the home, clinic, school, doctor's office, or emergency situations—and according to the age of the child and the severity of his condition.

The nurse also must keep in mind that parents often fear censure or reproach by those in authority and, in their effort to gain approval, may hide their feelings or hold back information regarding the child. By phrasing open end questions and restating the parents' comments, the nurse gives them an opportunity to examine their feelings about themselves and the child. She listens calmly, accepting and encouraging the parents to express their negative feelings in order to help them clarify their own thinking.

Health professionals are better able to help a child if they understand some of the family's fears. It is not unusual for children to sense the parents' apprehension about hospitalization. I have found it helpful to ask the parents about their past hospitalizations and talk about their hangups in an attempt to separate their experiences from the child's experience.

A hospitalized child with sickle cell anemia may ask questions that his parents are unprepared to discuss: "Am I going to get well?" "Am I going to die?" Other questions of this type may appear in a disguised form. By telling the parents how to recognize the child's apprehension and encouraging them to let the older child talk about the unpleasant aspects

of the disease when he asks unexpected questions, the nurse provides anticipatory guidance that enables the child and the parents to adjust to reality.

The nurse also tries to relieve the child's anxieties about his illness. One way of doing this is to allow the child to explain what is happening to him, and to listen closely to what he says. Role playing of a doctor or a nurse often encourages a child to voice some of his own apprehensions. The young child often expresses his frustrations best through play activities involving finger paints, clay, singing, drawing, dolls, music and noise, and pounding boards.

A child's problems

The child with sickle cell anemia is faced with many of the following problems that the well child does not face:

- ☐ He has to visit the doctor and go to the hospital frequently.
- ☐ He takes special medications.
- ☐ He needs protection from colds, pneumonia, intestinal upsets, and other infections that may precipitate crises.
- ☐ He suffers from episodes of crisis lasting approximately 1 week and occurring several times a year.
- ☐ He is thin and small for his age.
- ☐ He may exhibit feelings of inferiority because of his inability to compete physically with his friends and classmates.
- ☐ He is frequently absent from school and is sometimes behind his age group.

The nurse can alleviate some fears of the parents of a school-age child by stressing the following positive factors:

- ☐ Sickle cell disease does not affect intelligence.
- ☐ Between the crisis episodes the child may join in the usual activities of his age group, with the exception of strenuous sports that result in fatigue. Physicians hold differing opinions about the sports and activities an affected child may safely engage in.
- ☐ Parents who know in advance that their child may not always be able to participate in strenuous sports can steer him into school, church, and other activities in which he can excel. Activities that may earn the acceptance of friends in his age group include art, painting, handicrafts, debating, composition, chess, checkers, and monopoly.

Through informal counseling the nurse can do a great deal in helping parents recognize and anticipate the needs of a preschool child entering the hospital for treatment of sickle cell anemia for the first



Nurses, a social worker, and a mother make plans for hospital discharge and home care of a child with sickle cell anemia.

time. A child usually reacts to separation from his family in three phases. The first phase is the period of protest; the second, the period of despair; and the third, the period of comfortable adjustment. Parents who have been advised in advance of what reactions to expect can ease the transition of a child from the home to the hospital. For example, the mother may ask the child to help select and pack the items he will need for his hospital stay. Or she may let the child draw a picture of the hospital, the doctor, and a nurse as she tells him what he will experience.

Hospital care

A child admitted repeatedly to the hospital in a sickle cell crisis or other emergency situations requires understanding and emotional support from nurses and parents alike, particularly in terms of previous traumatizing experiences that may have occurred in the hospital. He needs to be reassured that his parents have not rejected him. Parents should be encouraged to visit him regularly and, when possible, participate in his care so he does not feel that they have "given him up" to the hospital.

A child hospitalized in a sickle cell crisis requires the following kinds of medical and nursing care:

1. Administration of medication to relieve pain and antibiotics to control respiratory infections and pneumonia.
2. Administration of oxygen and blood transfusions as indicated.
3. Adequate fluid intake and output.
4. Proper nutrition through the serving of well-balanced meals.
5. Care of the skin, good hygiene, and precautions to avoid bruises and cuts that may lead to infection.
6. Maintenance of proper elimination.
7. Assurance of proper rest.
8. Encouragement of normal exercises and activity after the crisis state has subsided.

During the hospital stay, the health team provides medical and nursing care and the nurse continues to give anticipatory guidance to the child and his family. Since children often have distorted ideas about illness and what is happening to them in a hospital, a simple explanation of the procedures for treating sickle cell anemia should be given frequently to both

the patients and the parents. An older child can be encouraged to write a story about his hospital stay for discussion with parents and hospital staff.

To continue as normal a pattern of daily living as possible for a hospitalized child, numerous hospitals around the Nation have set up special programs to provide diversional activities. Aimed at meeting both the child's psychological and physical needs, the program at Freedman's Hospital is operated by a Recreational Therapy Department within the Department of Pediatrics.

Care between crises

Before a child with sickle cell anemia leaves the hospital, he and his parents need information about how to prevent or minimize crisis episodes. This vital role often falls to the staff nurse, although it may be assumed by any health professional. In counseling parents about the child's activities between the crisis episodes, the nurse may offer the following advice:

- Make sure you and the child know how active the doctor wants the child to be. If you do not understand, ask a direct question about what is prohibited.

- Do not overindulge the child with toys and gifts.

- Treat the child as normally as possible, but set and enforce limits for him.

- Answer questions about sickle cell anemia from other children in the family honestly.

- Explain the nature of the disease to older children so they will not resent the treatment and special care the child with sickle cell anemia needs. Usually older children welcome an opportunity to be taken into the parents' confidence.

- Serve well-balanced meals selected from the basic four food groups. Encourage frequent small meals when the child's appetite is poor and supplement the diet with milkshakes.

Other workers

I will not attempt to describe the team process by which professional and subprofessional health workers interrelate with each other, the young patient, and his family. However, I will describe briefly some of the team members at Freedman's Hospital and their roles in caring for the child with sickle cell anemia.

In addition to the physician and the staff nurse, the dietitian, child psychiatrist, social worker, public health nurse, physical therapist, and speech therapist are members of the pediatric health team. The teacher and the school nurse often assist the team.

The dietitian plays a key role in interpreting the dietary needs of the child with sickle cell anemia to his family. In an informal discussion with the mother, she suggests ways of making liver and greens appetizing, but points out that the child should not be forced to eat liver or any other food. After the mother and the dietitian review the basic four food groups and discuss selection of foods to meet the nutritional needs of the child, the dietitian encourages the mother to serve basic foods to the entire family. Frequently mothers ask the dietitian to recommend foods that can be substituted or exchanged for those in a special diet. The dietitian also reports to the health team about nutritional problems.

The child psychiatrist provides individual counseling to the parents upon request, and explains the effects of sickle cell anemia on child behavior, growth, and development.

The social worker cooperates with the physician, hospital staff nurse, and public health nurse in planning and coordinating activities related to discharge of the young patient. Other major activities of the social worker include evaluating family relationships, assessing the parents' acceptance and understanding of sickle cell anemia, determining the financial impact of the illness on the family, and assessing and interpreting to the health team the behavior of families with psycho-social problems that may effect the adjustment of the patient to his illness. The social worker also coordinates hospital social services with those of community agencies.

The hospital-based public health nurse and the community-based public health nurse complement each other in planning with the parents prior to and following the child's discharge from the hospital. Cooperatively or individually they evaluate the family's ability to meet the needs of the child, assess available nursing care, health information, and provisions for meeting related needs of the child and his family, and assist parents in understanding and accepting the illness. They also report verbally and in writing their observations and assessments of the family to the pediatric team so followup medical and nursing care can be planned after the child returns home. By coordinating and providing liaison activities, these nurses promote continuity of care to the patient and family before and after the child's discharge from the hospital.

The physical therapist serves as a consultant on the pediatric health team. Among other services, she assesses the child's functional ability, strength, and mobility, and plans for the physical therapy. This

includes interpreting physical therapy needs to the members of the health team, particularly to the public health nurse, who is available to direct the family in carrying out recommendations.

The speech therapist also serves as a consultant to the health team. He evaluates the child's speech and language disorders and develops a treatment plan. Assessments are made periodically to determine progress and necessary modifications in the plan. In addition, the speech therapist explains the child's speech and language needs to the family.

Although not technically a member of the health care team, the school teacher who understands sickle cell disease obviously is better able to help the child and his family. The school teacher must try to protect the child from drafts in the classroom and exposure to colds and other infections that may precipitate a crisis. She needs to be aware of the signs of an impending crisis. These include complaints of pain in the back, arms, hands, feet, legs, or the abdomen; the appearance of a slightly yellow hue to the whites of the eye; and listlessness.

The child may have prolonged periods of absenteeism from school due to a sickle cell crisis. Therefore, the school teacher must be supportive to the child and family in regard to his school work and the chronic nature of his illness.

The school nurse, the hospital-based public health nurse, and the community public health nurse work cooperatively with the child and his family. The school nurse helps the teacher recognize symptoms of impending crisis and deviations from normal behavior that may be related to the child's illness. The nurse helps school administrators find ways of meeting the needs of children with sickle cell anemia and uses all her contacts with the child, teacher, and family for teaching about health and providing emotional support. Her activities also include regular reports to the health team about the child's school adjustment.

Continuous care

The health team's second major area of involvement in relation to sickle cell anemia is to ensure that the service to the child and his family is both coordinated and continuous. We are all too aware of the gaps in the health care system and the fragmentation and duplication in care and services.

I cannot help but wonder how often the information in the child's health records is transmitted from the private physician's office to the hospital when hospital admission is contemplated. When the child

transfers from one school to another, how soon does his health record follow? How well does the hospital plan with the public health agency for discharge and home followup? When information in health records is not transmitted among the various services in the community or utilized by them, the child is the loser.

Education and casefinding

The third area of concern for the health team is health education and casefinding. Surely our nation, with its highly developed communications system, is able to increase the awareness of thousands of black Americans about the disease, its disabling effects and high death rates, and other implications involved in its transmission to children. A nationwide multifaceted program, similar to venereal disease eradication efforts in the 1940s and 1950s, would involve informing the public about the disease itself, screening potential carriers, and counseling families at risk regarding the genetic aspects of sickle cell anemia.

Black mothers should be routinely screened for sickle cell disease in prenatal clinics, and, when the trait is found, given genetic counseling. Every black child admitted to a pediatric unit of a hospital should routinely have the test for sickle cell anemia. In addition, Head Start programs, schools, colleges and health clinics are appropriate sites for screening. Men inducted into the Armed Forces could be screened and given appropriate counseling as part of their physical examinations.

Members of the health team must give parents and young adults up-to-date, valid information regarding the sickle cell trait. In addition to information, health education programs must make available screening for sickle cell disease and genetic counseling so that the affected person is able to act on the facts regarding the inheritance of the disease.

¹ Scott, Roland B.: A commentary on sickle cell disease. *Journal of the National Medical Association*, January 1971.

² Marlow, R. Dorothy; Sellers, Gladys: Textbook of pediatric nursing. (Second edition.) W. B. Saunders Co., Philadelphia, Pa. 1965.

³ Scott, Roland B.; Kessler, Althea D.: Sickle cell anemia and your child—questions and answers on sickle cell anemia for parents. Department of Pediatrics and Child Health, Howard University College of Medicine, Washington, D.C. Spring 1971.

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TEENAGERS DISCUSS AGE RESTRICTIONS

Cecelia Sudia and Jane Harwood Rea

When Tui, living in a tribal society, proved himself a hunter or performed certain rituals, he was considered to have also proven his manhood. In such presumably simpler societies belonging to far-away places or times, a standard "rite of passage" from youth to adulthood can be noted.

In today's complex, technological world, however, there are no such clearly defined paths to adult status. Confusion about what makes one an adult in a particular situation is reflected in the differing Federal, State and local laws relating to the age at which a boy or girl may be treated as one.

How do teenagers themselves feel about the various age restrictions placed upon their activities?

A survey of 430 high school students conducted by the Children's Bureau in May 1970 shows that they accept some lines of demarcation between youth and adult status. When asked to discuss the age at which a person should be allowed or expected to engage in activities loosely defined as adult, their replies indicated that they expect to acquire adult privileges and responsibilities over a period of several years—but at a somewhat faster rate than is now the case. They also believe that more emphasis should be placed on competence and less on precise age.

The students questioned ranged in age from 15 to 19 and were randomly selected, as in the previous Children's Bureau inquiries, from lists of students enrolled in college preparatory courses in metropolitan areas of the four main regions of the United States (Northeast, South, Midwest, and West). The sons and daughters of fathers whose employment ranged from unskilled jobs to professional and managerial work, over 80 percent of the students were white, and almost one-fifth black.

What were the issues these youngsters considered most important—and why?

First in importance—and by a wide margin—was the issue of eligibility to vote, for the data were collected before the age requirement for voting in all elections had been lowered to 18. Next in importance were age restrictions on movie attendance, followed by age relating to service in the Armed Forces. Age restrictions bearing on jobs, purchase of liquor and cigarettes, school attendance, driving, and access to confidential medical care were also of sufficient importance to prompt considerable comment. Of lesser interest, but still discussed by more than a fourth of the teenagers, were adult status in court, and age in relation to marriage, childbirth, and financial responsibility.

Should there be age limits?

The Youth Reporters indicated that young people today are willing to accept the idea of some age limits, but are very impatient with certain specific limits now in existence, particularly those whose main function is moral protection. As one observed:

"Ironically it is our Federal government who expects our old brothers and boyfriends to fight the wars, help protect this country, and to help build the country into an even better stronger nation. All of this is what is expected of us but we cannot vote, marry, or even see a movie because we aren't considered adults enough—it's like telling an eighth grader he can't tie his shoe because he's too little!"

Many of the students were relatively conservative while others referred to the issue of age as a matter of relationships with parents. They spoke of the conflicting expectations of adults who seem more interested in seeing young people demonstrate responsibility than they are in extending privileges to them, and of the rigidity engendered when specific ages are used as cut-off points. As one student said:

"Then once again we come back to the first Youth Report—The Generation Gap. If there is communication between parents

nd child then neither will be satisfied by the age limits set on certain things. If kids would only sit down with their parents, talk and LISTEN, maybe an understanding would be reached and many complex questions solved."

In summarizing the responses, two ratings were made for each issue: the number of young people who responded and their opinions on the issue's importance. In general the two lists matched although there were minor variations. For example, although the movie issue was described as relatively unimportant, it was frequently mentioned, while the medical care issue was considered "very important" by the fewer number of students who discussed it.

Replies were received from only 46 students (34 percent), which is considerably less than the number who responded to the previous Children's Bureau questions on subjects of greater interest to them. (See "The Generation Gap in the Eyes of Youth," *Children*, March-April 1970, and "Drug Use Among the Young: As Teenagers See It," *Children*, November-December 1970.)

The complete findings of the report on age restrictions will be published by the Office of Child Development as Youth Reports No. 3. A summary follows.

The inconsistencies of a society that idealizes individual achievement but bases adult status on the attainment of a certain chronological age were pointed out. Youth Reporters were quick to state that age confers neither competence nor maturity—that age is not a measure of adulthood. Others resent the impersonality of a system that is not responsive to individual differences:

"... the magic age for a person is 21. He is then an adult and

has 'arrived'. If so much importance and important matters were not dependent upon this age, I think responsible people would accept and appreciate youth more."

"... I can't possibly give a cure-all by naming *the* age for everything—everyone matures at a different rate—everyone *is* different. Perhaps this is the problem today—considering the people as a blob ('silent majority', 'the masses', etc.) instead of as individuals."

Many teenagers claimed that their competence has been increased by the type or level of education they are receiving and believe that the statutory limits should be reduced in whole or in part because of this greater competence. As one put it:

"The pace of education is constantly increasing. I and my friends can look at our younger brothers and sisters and say, 'I never learned things that advanced when I was his age', just as our older brothers and sisters say the same things about us. Just from this personal experience we can see the rapid changes."

"Everyone matures at a different rate—everyone is different."

The students recognized that performing "adult" behaviors before one has attained the legal age enables one to *appear* adult. They rarely accepted the rationale which justifies many age restrictions as protection for young people who are too immature to exercise judgment, or who might be exploited by parents or other adults.

Voting

Youth Reporters definitely feel they are competent to assume vot-

ing responsibilities and indicated that their education has been important in preparing them for this role. They believe they have the qualifications necessary to understand the issues and to responsibly exercise the right to vote. "We are better informed than our parents were."

Some of the Reporters indicated an undercurrent of scepticism regarding the actual value of enfranchisement. One noted:

"A part of our learning, emphasized slightly every 2 years and heavily every 4, is the power and responsibility of the voter. At the same time this emphasis is felt, the contradiction of the teaching appears: men, unfit for office because of actions or incompetency, are elected again and yet again, and proposals designed to better lives . . . are defeated."

Service in the Armed Forces

Service in the Armed Forces is of interest to this generation of high school youth, because their age group is very personally involved, and also because it is a subject of considerable discussion in the country as a whole. Age was not the important issue, however. In effect, the students used the question on age as an opportunity to sound off on their attitudes toward the war in Vietnam or the draft as an institution. While a minority (11 percent) indicated a willingness to support the present system, this support seemed unenthusiastic.

Twenty-nine percent recommended that the age for service be higher. "Draft only those over 50" or "not before 21, if that's when you can vote." Several mentioned that service should be after college, or after education is completed. "No teenager should be drafted nor allowed to volunteer."

"A person of 25 has more experience with life's problems and is more capable of doing a better job on the battlefield than an 18- or 19-year-old who may easily become panic stricken in the face of danger," explained one teenager.

It is particularly notable that military service is the only issue on which a sizable number of students suggested an older age requirement and invoked the argument that youth needs protection. This presents a considerable contrast to the strong feelings on almost all other issues—that age limitations should be lower, not higher.

Movie restrictions

More than 85 percent of the young people who commented on this issue are opposed to the present system of restricting movie attendance of teenagers, rejecting it as unacceptable, ridiculous, and easily evaded. This is the highest negative response received.

Teenagers pointed out that they are limited in the number of places they can go and that consequently movies are a popular form of recreation. Therefore, they must regularly contend with a code that is set up for their protection, yet seems to outrage their growing sense of autonomy, encouraging them to lie or otherwise seek to evade the regulation, and perhaps prompting them to hold cynical views about regulations in general.

The largest proportion of students, a little less than half, said there should be no restrictions.

"Kids already know about sex; it's the *adults* who flock to X movies," one student asserted.

"As far as attending any movie, I think that it is ridiculous to set up arbitrary age limits and, in effect, say to a person, 'you are not mature enough now to see this pic-

ture, even though in 3 weeks you will be 17 and magically you will suddenly gain the necessary maturity.' I know several 18-year-olds whose maturity would be severely taxed by a Donald Duck cartoon. Age is not the criterion; it is the person's faculty to objectively and intelligently observe and interpret what is happening on the screen that is important," said another.

Or again:

"There is one item that really bothers me, however; the idea of movie censorship. I see this as illegal, and an intrusion into my personal affairs by 'Big Brother.' I don't appreciate having to lie in order to see the best movie of the year."

Another sizable proportion of youth, almost one-fourth, remarked that the code is irrelevant because it isn't enforced.

"It seems to me that some people place a rating or restriction on a movie to put their own morals to rest."

Some students suggested that pictures be given ratings but that the decision on who should attend be a matter of personal choice of the young person alone or jointly with his parents.

Jobs

Most of the Youth Reporters apparently see the age restrictions on job-seeking as somewhat arbitrary infringements on the rights of young people, while a very few recognize the protective rationale behind them:

"If there were no age limit, I think many parents would force

their children to work at a very young age."

While the students feel that age limitations on obtaining a regular job should be lower and more flexible ("should depend on competence, not age,"—nor "on hair"), the main problem seems to be the availability of jobs for young and relatively inexperienced workers.

"It is virtually impossible for someone under the age of 18 to obtain a regular job. There are some part-time jobs available, but not many. Many businessmen are afraid to hire young people because they feel they are irresponsible. Storekeepers refuse to accept the responsibility for minors."

Driving

Most of the panel supported the present age for acquiring driver's license in their respective States, but feel that the emphasis should be on competence, not age.

"The age when a person is capable of driving a car is very flexible. It completely depends on how mature they are, not whether they can reach the pedals."

Some mentioned the difficulties and expenses involved in owning a car and there were also complaints about the "ridiculously high insurance rates" for teenage drivers.

Generally speaking, however, the students did not place great stress upon the matter. The responses might have been more concerned if most students queried had been younger.

School-leaving age

Since the high school students queried were almost entirely college-bound, few were interested in the question of the minimum age at which they could leave school and most feel that it is desirable to continue schooling

ing as possible. Nevertheless, some see a need for a more flexible system of education. They believe that the school-leaving age should be more a matter for individual decision and that re-entry into school should also be possible without penalty. They are of the opinion that those students who are miserable in school and rebel against any form of teaching are causing more harm than good" and should not be required to stay in school. One suggested:

"For these people, a rule should be set up where they are allowed to leave school when they feel like it and give themselves a shot with life on the outside world. If they can't do it, they could always come back to school. Once they see that it is difficult to make it without an education, perhaps they would work harder than anyone in school to see that they got through."

Several Reporters also emphasized that the way should be open for students to change their minds after leaving. They suggested that dropouts should be allowed to return to regular classes if they wish, and not be relegated to adult education programs, or to night school. Explained one teenager:

"I know very well at least five intelligent people who have decided to leave home and school for several months. When they return, they have a large and unfair disadvantage in that they are placed in the local continuation school. If high school were optional, they could have resumed their place without being put in a stifling atmosphere that insures a dropout in a capable student."

More than 40 percent of the Reporters expressed the view that the present age for leaving school

(usually 16) is acceptable. Almost as large a group feel that the age for leaving school should be advanced since one "needs all the education he can get." As one said:

"The law is trying to protect people from themselves. In many states children must attend school until they are 16. In this way, people won't make the mistake of dropping out."

Slightly over a tenth of those commenting on this issue feel that the age should be lower: It "should be optional after the ninth grade" or at age 14 or 15, for "if they don't want to stay, they waste everyone's time."

"Once dropouts see that it is difficult to make it without an education, perhaps they would then work harder than anyone in school to see that they got through."

Others believe that there would be better cooperation if attendance were voluntary and recommended a "flexible school system, which could handle individual needs and enable students to be in school-work programs instead of leaving school for a job."

Confidential medical treatment

Only two out of five of the students who commented were interested in confidential medical care for teenagers, and one third of these believe that the age limit should be much lower than 21—from 15 (a few) to 18. Almost one half said there should be no age limit at all:

"A doctor's visit is supposed to be held in confidence. It is for adults and should be for us."

Another Reporter explained:

"In an unfortunately large number of cases, adolescents refrain from obtaining medical assistance because it would involve the embarrassment of informing one's parents. We feel that it is essential that teenagers be given without parental consent any medical treatment that is necessary to preserve their health and special prescriptions such as birth control pills that a doctor agreed were safe and for which there was a justified need."

A minority of five students endorsed the present age, or recommended that it be higher.

The issue of medical care probably impinges on family relationships more than other issues since problems here—as when a student seeks a prescription for contraceptives, treatment for venereal disease, or requires emergency help for a drug overdose—are almost certain to conflict with strongly held family values.

Many students expressed misgivings or more conservative values about the ease with which medical treatment should be made available. One young man recommended confidential treatment for venereal disease, but not for birth control. Another wanted parents specifically informed about VD and birth control, but not about other less controversial services.

Some students would also limit "medical freedom" to those able to meet the required payment.

Marriage and parenthood

Youth Reporters seemed to lack familiarity with the legal requirements in their respective States governing the age at which young people may marry without paren-

tal consent. (The age varies, but is below 21 for girls in many States.) Such permission is the major exception to ordinary contract laws, which specify 21 as the age of majority. This is the only area in which adult status may be granted to women earlier than to men, an exception which seems related to standards of male financial responsibility.

A little less than one-third of the Reporters responded to this item. Their opinions were relatively conservative, and two major views emerged. The largest proportion—about a third—think the present age is about right. Their comments seem to indicate wariness and an unwillingness to move into this adult arena. The other major view, expressed by a fourth of the Reporters responding, insists that there should be no age limit related to parental consent. This group seems more concerned with parent-child relationships and the autonomy of the youth generation, than with age per se: "Parents shouldn't be able to veto."

A few recommended 21 as the right age. Only one Reporter in ten believes the age restriction should be lowered. Among this group, the most frequently specified age is 18—the age suggested by the American Law Institute in its model legislation regarding age of marriage, without parental consent, for both men and women.

Closely related to the issue of appropriate age for marriage were the responses to the question of appropriate age to have a first baby. An analysis of the responses to the latter question indicates that many Reporters interpreted it as what is the appropriate "legal age to have a baby"? and accordingly said that there should be no age

limit, or that parenthood could not be legislated.

A number of comments, however, represented a range of teenage thinking: "babies should come after marriage", "if parents won't consent to their early marriage, girls take revenge on them and get pregnant," and "with today's growing population, young people should be encouraged to limit the number of children they have."

Juvenile court cases

On the question of age status in juvenile court cases, opinions varied widely. According to present practices, youths 18 years of age in most States and 16 years of age and older in a few States (or younger with a waiver from the juvenile court) are treated as adults, and are tried in criminal courts. While almost one-third of the students commented on the issue, only a few ranked it as either important or unimportant. Of the one-third stating an opinion, slightly over one-fourth rated the present age as satisfactory, while an equal proportion feel that if the age were lower, it would serve to deter crime and college militancy. About the same number believe that the age should be higher.

"The law is trying to protect people from themselves."

"It is unfair for a person as young as 14 to be tried as an adult in a criminal case when this person is given absolutely none of the privileges of an adult."

Some students feel that there should be no specific age limit and that the present juvenile court system is unconstitutional. These

students tended to recommend that all young people should be treated as adults, and that decisions should be individualized.

Cigarettes and liquor

The restrictions on access to cigarettes and liquor are considered irrelevant because the law isn't enforced. However, almost half of the Reporters feel that the legal age for access should be lower, and 8 percent want no restrictions at all. Some students see smoking and drinking as behaviors adopted to look "cool" or to rebel against authority.

One fourth of the Reporters believe that the present age in their State is fair and a few feel strongly that adequate enforcement of restrictions would discourage younger students from smoking and drinking.

Judging from the fact that they seem to ignore the health factor involved in smoking and drinking it would seem that more effective education is needed in this area.

Financial responsibility

While the Reporters generally favor lower ages for assuming financial responsibilities, they apparently have little information about the responsibilities involved in such practices as installment buying, rental leases, and other aspects of adult life. The response also indicates that these young people are not aware of their lack of information, strongly suggesting that more educational programs are needed in this area, too.

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MENTAL RETARDATION AS A SOCIAL PROBLEM

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Margaret Adams has written an excellent book on the social dimensions of mental retardation.* With clarity and sensitivity she has presented the "malevolent stereotype" of mental retardation and described its effects on society's treatment of the mentally retarded.

However, Miss Adams, a consultant in social work at the Walter E. Fernald State School in Massachusetts, has not limited the scope of this book to practitioners in the field of mental retardation and social work. Miss Adams writes from broad experience as a caseworker both in the United States and England. The book has broad application to the problems that relate to chronic disability—be they physical, social, emotional, or intellectual—faced by professionals in all disciplines.

We know that people follow similar patterns in responding to stress and crisis. But their specific problems vary, requiring adaptation of the basic helping process to fit the particular situation. Helen Harris Perlmán has said that the essence of social casework lies in its aims to facilitate the individual's social adaptation—to restore, reshape, or reinforce his functioning as a social

being. It is precisely this general concept of social adaptation and social functioning that Miss Adams discusses in its specialized application to the problems of the mentally retarded.

I don't know of any other book that gives a clearer, more logical explanation of the importance of viewing mental retardation as a social problem or a better presentation of the variety of social services needed by the mentally retarded. The first two chapters on the socioclinical nature of mental retardation and the historical background to services sum up complex topics in a lucid well-organized fashion. Miss Adams sets the conceptual framework for her presentation of social dimensions at the same time that she discusses the nature and characteristics of mental retardation.

All of us in the helping professions—social workers, doctors, nurses, teachers, rehabilitation counselors—are now being asked to work together in preventive and rehabilitative programs. Federal legislation has fostered a coordinated, interdisciplinary approach to maternal and infant care, Model Cities, community health, community mental health, and other welfare and educational services. This book spells out the applicability of an interdisciplinary approach in one problem area and could therefore serve as a model in other areas.

Mental retardation is, of course, not the only area in which society has been unwilling to assume full responsibility for prevention and rehabilitation. Another example is the chronically dependent population that requires public

assistance. Miss Adams cites many parallels between the areas: the lack of sufficient funds for prevention, rehabilitation, and basic maintenance; the social isolation; the punitive legislation; and the denigration of professionals who work with the people affected.

I think that services to the mentally retarded can serve as a barometer of a nation's willingness to support its dependent citizens.

Time-currency society

How willing are we to assume responsibility for helping the chronically dependent? Perhaps we should take a lesson from Edward de Bono in finding new solutions to our old problems.¹

"'Conventional thinking' is 'vertical,' which means that you accept fixed concepts and move forward from them toward a solution," he tells us. "'Lateral thinking,' on the other hand, allows you to escape from fixed concepts and move sideways in an attempt to look at things in a different way. Vertical thinking takes place after you have accepted fixed concepts; lateral thinking takes place before you have found new ones."

Professor de Bono, who teaches mathematics and investigative medicine at Cambridge University, has suggested that we adopt a time-currency concept in which effectiveness rather than efficiency becomes the basis for society's evaluation of an individual's contribution. This would replace the current value-currency concept "in which the value provided by a person's work is exchanged for the value he absorbs as cost."

***MENTAL RETARDATION AND ITS SOCIAL DIMENSIONS.** Margaret Adams. Columbia University Press, New York, N.Y. 1971. 396 pp. \$10.

Efficiency, as defined by de Bono, means obtaining as high an exchange rate as possible. If one man paints a lamppost in 2 hours, that is efficiency. If 10 men paint the same lamppost, that is not efficiency—but it still is effectiveness.

"In a time-currency society a person is under no obligation to provide value," de Bono explains. "Instead, he provides time. Thus students, the unemployed, and people who have time and energy left over after competing in the value-currency society can become part of the urban solution by caring for the environment or for other people. In return, they can receive pay and services." I believe this approach, if properly applied, could revolutionize our view of the value of the mentally retarded as members of society.

The problems of the mentally retarded cannot be separated from those of society as a whole, Margaret Adams asserts. In her analysis of the social dimensions of mental retardation, she has rightly transferred emphasis from the traditional medical and clinical aspects to broader human aspects. Viewed as a medical problem, mental retardation appropriately employs the clinical model of diagnosis and treatment. Viewed as a social problem, however, mental retardation requires the public health model of prevention and intervention.

Miss Adams points out a most significant statistic: of the total population of mentally retarded in the United States, 11 percent fall within the ranges of severe retardation and 89 percent fall within the ranges of mild retardation. Because economic and social deprivation is a major cause of retardation, the majority of the mildly retarded come from poor families.

After World War II pressure groups for the mentally retarded were organized by middle-class parents, Miss Adams recalls. Spurred on by their concern for severely retarded and organically-physically handicapped children, the pressure groups have focused their efforts on obtaining expanded fa-

cilities, funds for basic research, and programs for the severely retarded. For example, most States have enacted legislation to detect phenylketonuria in the newborn, although the disease affects a very small percentage of the total population of mentally retarded.

Only recently has there begun to be a recognition of the parallel need for legislation to help the large number of the mildly retarded who live with their families instead of in residential institutions. The changing emphasis takes notice of the mentally retarded both as deprived members of society entitled to a first claim on social services, and as persons who can benefit from and respond to a social approach to their problems. As a result more money and services are beginning to be provided to the mildly retarded.

Social work factors

Two key factors emerge for social work consideration, the author says. One is that basic social work principles are applicable to the mentally retarded. The same methods of case work, group work, and community organization that produce a positive response from any client also can produce constructive interaction with the mentally retarded and their families. Miss Adams recognizes that social workers need some specialized knowledge to work with the mentally retarded, but she says it can be made available through consultation or inservice training.

The second key factor is the involvement of the client in his own helping process. Both public and voluntary social agencies have made significant progress in maximum feasible participation of clients in policymaking, staff hiring and firing, and budget allocations. In addition the agencies are making their clients responsible for using the help that is offered.

For the mentally retarded, who are limited in their intellectual ability, maximum participation in all realistic decisions leading toward independence is especially important. This is a chain reaction: people treated with the ex-

pectation of good behavior tend to behave more independently, thereby creating more acceptance for themselves.

Although this is by no means a "how to" book, there is practical discussion of the techniques and skills needed to help the mentally retarded and their families, with a wealth of case excerpts that illustrate precisely the points enumerated. Miss Adams gives an excellent explanation of the social work technique of encouraging the client to discuss a problem through narrative presentation.

In a group or interview, the social worker who uses this technique asks the client what she *did* about her feelings at a time of crisis. For example the social worker might pose the question, "When you first found out that your child was mentally retarded, what did you do?" In this process the client makes constructive responses about her behavior instead of recounting negative feelings.

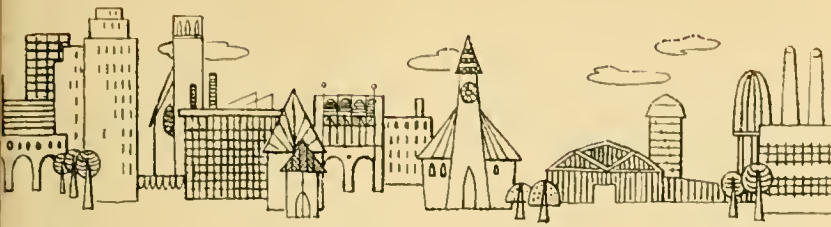
In chapter after chapter, Miss Adams shows the importance of continuously making options and choices available to the mentally retarded client, and reasserts that concrete services are as necessary as sensitive counseling. She points up the need for a continuum of services to meet the ebb and flow of the client's demands at different points of crisis in a life cycle. In a masterly summary Miss Adams outlines the essential components of a community organization program.

The chapters "Some Concepts of Casework" and "The Professional Relationship With the Mentally Retarded Client" offer much for practitioners to apply to their own practice.

"Mental Retardation and Its Social Dimensions" should, I believe, stimulate the thinking of all persons concerned with the social dimensions of chronic problems, regardless of their disciplinary affiliation. It is an important addition to the literature as well as a pleasurable one because its style makes this book a joy to read.

¹ New think for New York . . . Cf/Edward de Bono. *New York Magazine*. April 5, 1971

HERE and THERE



H.R. 1—developing standards

Under the New Social Services Provisions of H.R. 1, now before the Congress, \$150 million would be authorized for payments for foster care and adoption services. This would mark the first time that a substantial amount of Federal funds would be made available for these services.

The proposed legislation also provides that payments for foster care be made only to an agency, institution, or person whose care meets standards prescribed by the Secretary of the Department of Health, Education, and Welfare.

Several task forces and committees have been working since midsummer to establish standards for foster family care and institutional care.

Taking the lead in this activity is the Office of Child Development, the standard setting agency for children's services in the Department. It is working in close collaboration with the Community Services Administration, Social and Rehabilitation Service, which would administer the funds and implement the standards.

A national committee composed of representatives of the Child Welfare League of America, the American Public Welfare Association, OCD, CSA, and other Federal and State agencies met in July to discuss the project. Task forces were then formed to develop standards in specific areas.

Beatrice L. Garrett of the Children's Bureau, OCD, heads the National Task Force on Federal Standards on Foster Family Services, a 14-man group whose members are preparing draft standards to cover the 35 areas identified within the broad field of foster family services. They include representatives from each of the 10 regions served by the HEW field offices—foster parents, directors

and staff members of State agencies and representatives of urban and voluntary agencies.

Each member of the national task force, in turn, has formed a committee to consider standards related to two or three of the major areas to be covered. The final draft standards will also include criteria for judging how well the standards are being met in the States.

Draft standards for institutional care of children are being drawn under the leadership of Martin Gula of the Children's Bureau, OCD. The standards are being discussed and reviewed in a series of regional meetings attended by representatives of Federal, State, and local agencies, administrators of residential institutions and those most directly affected by the standards—the children who are being cared for in the institutions and their parents.

H.R. 1—day care planning

The Office of Child Development has established a Federal Interagency Policy Group on Day Care Planning to guide overall planning for day care aspects of H.R. 1, now pending before the 92nd Congress. The proposed legislation calls for the development and purchase of day care services, with programs to be implemented upon enactment.

Under the chairmanship of Saul Rosoff, deputy director of OCD, the 20-member group is composed of representatives of the Department of Labor, the Office of Economic Opportunity, OCD, Social and Rehabilitation Service, Welfare Reform Planning Office, Office of Education, and the Office of the Secretary in HEW. The policy group has been meeting biweekly since July to consider policies and options regarding day care and to recommend a coordinated strategy for carrying out the Fed-

eral responsibilities—including standards for child care and the development of facilities.

Staff members from agencies having a special interest in day care planning have been assigned to an OCD team working under the policy group's general guidance.

Policy papers, proposed regulations, guidelines, and administrative procedures are being prepared, together with estimates of day care resources and needs. Priorities for Federal funding are also being considered.

Day care needed

As of December 31, 1970, about 3,600 mothers eligible for the Work Incentive Program (WIN) could not be referred for enrollment by welfare departments because of lack of child care arrangements. Reports from 45 States show that arrangements for care were not available for 8,500 children receiving aid to families with dependent children (AFDC); of these, a little less than half were under 6 years of age and the rest were between the ages of 6 and 14. Their mothers comprised a little less than a tenth of those who needed child care arrangements in order to accept work or training in the reporting States.

In the 3-month period ending December 31, 1970, the number of mothers and other caretakers enrolled in the WIN program increased by 5 percent and the number who could not be enrolled solely because of lack of child care arrangements decreased by 3 percent from the previous quarter.

Of the 127,000 children whose mothers were enrolled in the WIN program in 48 reporting States on December 31, 1970, almost half were cared for in their own homes, a tenth in relatives' homes, a fifth in day care facilities (over half of which were family day care), and a fifth under other arrangements. The latter group included 4,000 children aged 6 through 14 who looked after themselves.

Dental education

A 2-year dental education demonstration project that enables sixth grade students to discover for themselves the cause and prevention of some dental diseases was initiated in some Cleveland schools this fall by the city's Department of Public Health and Welfare. The project will include 3,000 children—

1,500 in the study group and 1,500 in a control group.

The project is an expansion of a 1970-71 pilot study, which was conducted with 200 sixth grade students from middle- and low-income families, including Polish, black, and other ethnic groups. It is based on two assumptions: (1) a change is needed to make the traditional methods of teaching dental care more relevant for children and teachers, and (2) children will be motivated to follow proper dental practices if they are aware that tooth decay and periodontal disease may be caused by plaque, a bacterial infection that can be controlled.

About 100 persons—dentists, dental hygienists, dental students, and classroom teachers—have been trained in the special technique for teaching dental health. The success of each group in motivating children to control or prevent dental caries and periodontal disease will be measured through dental examinations of all children in the project every 6 months.

In the project, dental health is presented to participating sixth grade students as a special unit of health education, with 1-hour classes each day for 5 consecutive days. First the teacher describes plaque as an extremely sticky, clear or whitish film that attaches itself to the teeth and produces acid.

Students learn to take samples from their teeth and examine the living bacteria under a phase microscope; they also learn to use a disclosing solution to identify plaque that may be overlooked on a visual examination. The lessons also include chemical demonstrations of acid production in the mouth, the role of nutrition, three short movies on dental health, and instructions on staining, flossing, and brushing teeth to prevent or control the buildup of plaque. During the next 2 school years, students will examine each other's teeth weekly for plaque.

The sixth graders are encouraged to teach members of their families why and how dental diseases occur and what can be done to stop such diseases. Written instructions and diagrams of methods for controlling plaque will be distributed to families, supplemented by a dental health information program using radio, television, and newspapers.

Charles A. Clark, D.D.S., dental planner in the Division of Community Oral Health, is director of the project.

(Address: Department of Public Health and Welfare, Room 23, City Hall, 601 Lakeside Ave., Cleveland, Ohio 44114.)

Mental health

The National Institute of Mental Health is marking the 25th anniversary of the passage of the National Mental Health Act by the publication of "The Mental Health of the Child," a compilation of 42 selected reports on projects it has supported in the field. The book is designed, as Institute Director Bertram Brown notes in the foreword, to serve as "... a reminder of the beginnings that have been made—and of what more we can do. It is intended to stimulate further the creative approaches of research personnel and to provide information of value to clinicians and all those others who deal directly with the child . . ."

Grouped into four major areas the reports cover studies and demonstrations in prevention, factors that influence a child's mental health, advances in diagnosis and treatment, and basic studies of child development. Although most of the reports have been published before—in the Institute's "Research Project Summaries" and "Program Reports" series—seven, which describe recent advances, are new.

These include three appearing in the first section, which looks at the child in his normal environment at home, in school, and in the community. They cover "Nursery Schools in the Service of Mental Health," which reports on a project planned to promote interfamily, interracial relations; "A Pre-school Program for Disadvantaged Children," which describes a program serving 3-year-olds from low-income, Spanish-speaking families; and "Operation Hope: Educating New Leaders," an experimental training program in which 20 students from Los Angeles ghettos are being helped through college and encouraged to prepare for careers in mental health professions.

Other new studies reported are "Schizophrenia: New Light from the Life Histories and Biochemistry of Siblings and Twins;" "Studies of Child Abuse and Infant Accidents," based on research conducted by the staff of Children's Hospital in Pittsburgh; "Infant Stimulation as Part of Well Baby Care," a research program conducted with unmarried teenage mothers at Washington, D.C.'s Children's Hospital;

and "The Development of Intelligence in Babies," a study conducted by Jerome S. Bruner, director of Harvard University's Center for Cognitive Studies.

("The Mental Health of the Child: Program Reports of the National Institute of Mental Health," Public Health Service Publication No. 216S, 1971, 588 pp., \$5. Copies are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.)

Mental retardation

In Rochester, N.Y., plans for a new State institution scheduled for opening in 1973 have already resulted in steps to strengthen and expand community resources for children with developmental disorders and to tie the institution's program closely to other community programs. To be known as the Monroe Developmental Center, the institution will provide residential care, training, and other services to children and young people who suffer from mental retardation, emotional disturbance or brain injury.

A pediatrician, Albert P. Scheiner, is center director. Since 1969 he has led a task force and the center staff in developing a coordinated program of comprehensive care for the mentally retarded in Monroe County.

The task force is comprised of representatives from the city school system, the University of Rochester School of Medicine and Dentistry, minority groups, mental health agencies, and consumers. The coordinated program includes—

- Outpatient services, provided by the Community Diagnostic Clinic operated by the Monroe County Association for Retarded Children. The clinic was opened in January 1970. Its services include a home care program staffed by a social worker and home aides for children too young or too impaired to participate in a center-based program; a diagnostic and habilitation program; a screening program conducted by an occupational therapist and a speech pathologist; an innercity preschool habilitation program conducted in the child's home community; and a diagnostic classroom.

- Residential care, to be provided by the Monroe Development Center. The center will emphasize short-term habilitation but will also accept children for

permanent care. The center's staff is already coordinating services of 18 community agencies.

- Teaching and research in developmental problems, provided by the University of Rochester medical school for physicians, psychologists, medical social workers, and other professional persons. The university's teaching-oriented Diagnostic Clinic for Developmental Disorders shares its staff with the Community Diagnostic Clinic. When the Monroe Developmental Center opens, it will be used as an observation and training resource by the university.

- Evaluation of the community's health services to the retarded. The university and the center will conduct evaluation on a continuing basis.

The basic planning for the center has been supported through local, State, and Federal funds, including a grant from the Rehabilitation Services Administration. (For further information: Monroe Development Center, 797 Elmwood Avenue, Rochester, N.Y. 1420.)

Advocacy

A new newsletter, *Advocacy for Children*, has been initiated by the National Center for Child Advocacy, with the guidance of an HEW interagency editorial advisory board. Designed for persons actively engaged in advocacy programs at State and local levels, *Advocacy for Children* will be issued periodically.

Since there are many interpretations of advocacy and many activities included under the term, the newsletter will contribute to clarification by reporting on activities throughout the country that are so identified.

For further information, write Jean Reynolds, National Center for Child Advocacy, Children's Bureau, Office of Child Development, Box 1182, Washington, D.C. 20013.

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Six demonstration projects involving child advocacy are getting started this fall under grants totalling \$656,000 awarded jointly by the Bureau of Education for the Handicapped, Office of Education, and the National Institute of Mental Health, Health Services and Mental Health Administration. The two HEW agencies are working together through a Joint Planning Committee for children, which selected the six projects from 33 applications.

All child advocacy projects seek to increase public awareness of the social, educational, and emotional needs of children and to improve community resources that serve children. Recipients of the 1-year grants are Central City Community Mental Health Center, Los Angeles; Prince Georges County, Md., public schools; Learning Institute of North Carolina, Durham; Philadelphia Urban League; Dede Wallace Center, Nashville, Tenn.; and Mexican-American Neighborhood Civic Organization, San Antonio, Tex.

Family day care

The School of Education at the University of Michigan is conducting a training and research program in the field of family day care, with a 1-year grant under Title IV-A of the Social Security Act.

Training is being provided for 24 low-income and lower-middle-income women who are licensed day-care mothers. Bi-weekly home visits are made by consultants who have received training and experience as teacher assistants in other early childhood programs. The consultants also receive continued training in the theoretical areas and techniques necessary for training day-care mothers.

Depending on the needs and interests of the day-care mothers, the consultants assist the mothers in organizing the day or arranging the physical setting, or both. Montessori methods, games, indoor and outdoor activities are taught to those day-care mothers that are interested.

In addition, the day-care mothers attend biweekly group meetings led by a student social worker with the assistance of the project director, a specialist in early childhood education, where they attempt to solve common problems through discussion. Several group meetings are set aside for workshops in art, music, and creative dramatics.

The goal of the project is to provide the day-care mothers with sufficient training and knowledge in child care and development to give them a sense of professional competence, and also to provide the consultants who are trainees themselves with a step upward. The consultants are employed on a half-time basis and receive stipends to enable them to finish academic work for a bachelor's degree in education.

The research component of the project will provide a picture of the family day-care mother—her attitudes,

concerns, and her environment—and will attempt to measure the effects of the training program on the children in care.

The project is directed by Melinda Green; the research director is Thelma Valenstein.

Adoption procedures

In response to many recent inquiries relating to adoptions, the Children's Bureau has prepared a summary of its official position on the "Termination of Parental Rights and Responsibilities and the Adoption of Children."

The Bureau has long held that the termination of parental rights and the adoption of children should require two separate judicial procedures, and that the termination procedure should be completed before the adoption petition is initiated. The parent-child relationship is so important that only through judicial action can the parent and child be completely divested of their rights and obligations to each other. And only through a judicial decree can the child legally be freed for adoption.

The Children's Bureau believes that all State laws should require these two separate procedures and that a child should not be placed in a prospective adoptive home until the parents' rights have been terminated.

Once the termination decree has been finalized, the only issue to be considered at the time the adoption petition is heard will be whether the child and the adoptive family are suited for each other. No issue regarding the natural parents' rights will then be placed before the court.

At present, only 16 States have provision for judicial termination of parental rights. The remainder have surrender, relinquishment, or release provisions, which are contractual arrangements with a social agency. The Children's Bureau considers these arrangements unsatisfactory because the rights and obligations of parents and children remain unclear.

Included in the discussion of legal steps and social services involved in adoption procedures is the Bureau's recommendation that guardianship of a child be given (at the time of the termination decree and before the child is adopted) to an authorized child adoption agency.

The 3-page summary is available from the Division of Public Education, Chil-

dren's Bureau, Office of Child Development, Box 1182, Washington, D.C. 20013.

Further information on the subject is contained in "Legislative Guides for the Termination of Parental Rights and Responsibilities and the Adoption of Children," Children's Bureau Publication No. 394, 1961 (reprinted 1968).

Children's conference followup

Plans are taking shape for the implementation of the recommendations of the 1970 White House Conference on Children, under the leadership of the WHCC Follow-Up Office located in the National Center for Child Advocacy, Children's Bureau, Office of Child Development.

An all-day August meeting in Arlington, Va., brought together representatives of 45 national voluntary and professional organizations and staff members of the Children's Bureau. A cross

section of the 1970 conference participants, the representatives discussed the views and actions of their organizations in regard to fulfilling the conference recommendations and offered suggestions on what OCD could do in the field.

Later the Follow-Up Office sponsored a series of meetings that examined recommendations related to each of the 1970 conference "cluster" areas—learning, individuality, health, parents and families, communities and environment, and laws, rights, and responsibilities. Attending were leaders and participants in the 1970 White House Conference and other persons knowledgeable in the specialized areas.

Robert C. Pekarek is director of the WHCC Follow-Up Office.

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"Overriding Concerns," a 16-mm. black-and-white film that discusses the

major issues of the 1970 White House Conference on Children, is being distributed nationally. It presents a conversation among spokesmen for groups of related forums, who identify the overriding concerns of the delegates. The film is available from the National Audio-Visual Center, Government Service Administration, Washington, D.C. 2040 (Rental: \$15.)

Correction

CHILDREN gratuitously awarded Ph.D. degree to Earledeen D. Badger, author of "A Mothers' Training Program—the road to a purposeful existence," (September–October 1971, 168.) Mrs. Badger and the editor wanted to set the record straight: she is registered occupational therapist who earned a master's degree in special education from the University of Illinois 1969.

RESEARCH GRANTS AVAILABLE

The Office of Child Development will consider applications for funding of research and demonstration projects in the following nine areas identified as priorities for fiscal year 1972 research appropriations:

Day Care

Development of models of day care which emphasize child development.

Child Advocacy

Projects conducted at the local level which demonstrate alternative methods for improving the health, education, and welfare of children.

Research on Racism

The study and development of early childhood intervention programs that deal directly with problems of racism; programs that develop and utilize the talents, skills, and experience of ethnic investigators; and projects that develop programs in coordination with black colleges and other research groups who will be helped to engage in OCD research and evaluation programs.

Parent Education

Child development and child care study programs for teenagers; projects that offer special comprehensive programs for pregnant school-age girls; and demonstration parent education programs for mothers in a variety of settings including the home and public pediatric clinics.

Programs for Children from Fatherless Homes

Demonstration projects to provide a male model for children, and projects which compare the effectiveness of volunteers, older adolescents, college students, young adults and retirees in providing such a model.

Television

Research on the impact of television on preschool children and their families and projects which compare the effectiveness of various technological developments, curriculum variations, and scheduling.

Children's Institutions

Demonstration of methods designed to effect change in the institutional care of children.

Adoption

Demonstration projects planned to increase the availability of homes for children who are difficult to place because of their age, ethnic identity or physical or mental handicap.

Emergency Services

Projects which demonstrate workable alternatives for the child who faces a traumatic home situation and/or is in the process of being removed from his home.

Further information on grants in these areas may be obtained from Duane Ragan, Office of Child Development, Research and Evaluation Division, P.O. Box 1182, Washington, D.C. 20013; Telephone: (202) 755-7740.

READERS' EXCHANGE

MITCHELL: therapy or education?

In "Occupational Therapy and Special Education," Marlys Marie Mitchell attempts to differentiate between the roles of these disciplines in the assessment, programing, and evaluation of treatments for handicapped children. (CHILDREN, September-October 1971.)

The author suggests that each professional must be well-grounded in his own discipline before a truly profitable interface can occur. Our experience in an interdisciplinary clinical program certainly confirms this concept.

One point made by the author needs clarification. Dr. Mitchell notes that the basic aim of special education is to overcome the deficiency that has made him (the handicapped child or adult) different. However, when the deficiency is chronic, as in the case of the severely mentally retarded child, the objective in either therapy or education may be accommodation to the deficiencies of the environment rather than remediation.

The procedures used in achieving the interdisciplinary mix deserve further elaboration. Both disciplines—occupational therapy and special education—must independently identify objectives and strategies for assessment before any negotiation can begin. Dr. Mitchell offers excellent examples of how both disciplines seek a similar objective: assessment of perceptual-motor skills, often through the same medium, such as toys.

The specific objective and the results of assessment may, however, be different for each discipline. In conjunction with the process of assessment, a set of crucial questions must be addressed by each discipline: What is the nature of the treatment program—therapeutic or educational? Who will implement the program? What are the expected outcomes? What time frame is projected? How and by whom will the program be evaluated?

After each person has assessed the case, implemented his treatments, and evaluated the effects of his prescrip-

tions for change, the process of role assimilation can begin. The objective, then, of an interdisciplinary activity is to cause a reexamination of role expectation within and between disciplines to determine the degree of role reciprocity needed for more effective services.

Who must provide the leadership to facilitate more successful joint endeavors between the disciplines? Dr. Mitchell suggests that administrators and supervisors of programs must provide the direction. I believe it is equally important that teachers and trainers of therapists and educators at the preservice and inservice level have a major role in the demonstration of more efficient and effective multidisciplinary and interdisciplinary models of service delivery to handicapped children and adults.

Leonard C. Burrello
*Program Director for Special Education
Institute for the Study of Mental Retardation
and Related Disabilities
University of Michigan, Ann Arbor*

BADGER: involving parents

Earladeen D. Badger hit the nail on the head when she wrote the article, "A Mothers' Training Program—The Road to a Purposeful Existence"! (CHILDREN, September - October 1971.)

I agree wholeheartedly with her statement, "Any program for the disadvantaged that directs itself to the education of *parents* hits the real target." I believe that for parent education to be truly beneficial to the child, both father and mother must be involved.

Since January 1967, I have been working first in Head Start and now in Parent and Child Center (PCC) programs that have emphasized parent involvement and parent education. In the West Virginia PCC program, parents and their very young children in isolated rural areas of Wayne and Lincoln counties are transported daily to two nearby centers, where they are provided an enriched environment and socialization experiences. The most important aspects of the centers are (1) a planned

stimulation program for infants and toddlers, and (2) a planned program of parent education that emphasizes equal participation of fathers and mothers.

Parent education in the PCC centers is planned cooperatively by parents and members of the central staff (nutritionist, nurse, child development assistant, and social services coordinator). Major emphasis is given to the total environment of the child.

Because of lack of medical resources in these isolated communities, particular attention has been given to health and dental education, first aid, medical examinations, nutrition, use of food stamps, and principles of feeding young children. Through the program, parents have become more aware of the importance of good health care for their children and themselves.

As in the program described by Mrs. Badger, the parents have been encouraged to provide educational activities at home. At both centers, parents have learned to use toys that they made themselves to help their own children develop new concepts.

Through involvement in PCC, many formerly shy, withdrawn parents have developed self-confidence and an awareness of their personal worth. Two parents now work in Head Start, another is director of a community center, and others are enrolled in training programs.

As Mrs. Badger said, "time is an important ingredient in any program that hopes to effect attitude change coupled with social action." The positive results of the PCC program in West Virginia have taken 2½ years of total commitment from the staff, a belief that low-income parents *are* interested in their children and *do* want to provide a good life for them, plus mutual trust, respect, and honesty.

To quote one of the PCC fathers, "We can do what we want to do."

Mary Jane Bevins
*Director, Parent and Child Center Program
Southwestern Community Action Council, Inc.
Huntington, W. Va.*

EPSTEIN: education for parenthood

A procedure that could avoid or at least minimize the negative aspects of a child's failure to achieve in school was suggested by a part of the summary report on the 1970 White House Conference on Children ("Priority for Change—Some Preliminary Proposals from the White House Conference on

Children" by Noel Epstein, CHILDREN, January-February 1971.)

The topic was the need for more education in "parenting" at all levels of human development. One suggestion was for older elementary age children to receive practical experience in parenting roles by adopting a kindergarten class.

It follows that a class of older children might adopt younger emotionally disturbed children and others who had not been able to advance in school with their own age group. The older students would assume a tutoring or parenting role toward the student who is 2 or 3 years younger chronologically and educationally. Their collective role would be to teach the younger child—through acceptance and example—how to function in positive ways in a "normal" educational setting.

The provision of 20 or so older children as models of acceptable behavior for an emotionally disturbed child should encourage consistent and positive responses. The accepting and acceptable group of older children should also provide the therapeutic support that the emotionally disturbed student needs. Other positive aspects would be the removal of the threat of failure from the younger child through the help of a tutor, a reduction of the number of unacceptable or regressive actions adopted by children to maintain their egos in a failure situation, and the possibility of the child's return to a class of his own age group without being branded a failure.

As a teacher of emotionally disturbed children, I have observed how well they can function on a one-to-one basis with volunteers when the pressures of grades and required assignments are removed. Another aspect of a good volunteer-child relationship seems to be a lowering of stress on the fragile ego of the child when he is not required to make comparisons between himself and other children who are successful in school.

In summary, I propose another choice for administrators faced with the need to remove a student from a class of his own age group for unacceptable dysfunctioning. The choice is to escalate him into a majority of older children who can serve as models of acceptable behavior with all the powers of peer pressure in their favor.

Tom Baty
Beloit of Ames
Ames, Iowa

guides and reports

DIRECTORY OF FEDERAL PROGRAMS FOR THE HANDICAPPED.

The Council for Exceptional Children, 1411 South Jefferson Davis Highway, Arlington, Va. 22202. 1971. 12 pp. \$1. (Discount for quantities of 10 or more.)

A compilation of Federal programs specifically designed to serve physically and mentally handicapped persons, presenting a description of each program together with information on its administration, authorizing legislation, and appropriation.

A STUDY OF BLACK ADOPTION

FAMILIES: a comparison of a traditional and a quasi-adoption program. Elizabeth A. Lawder, Janet L. Hoopes, Roberta G. Andrews, Katherine D. Lower and Susan Y. Perry. Child Welfare League of America, New York, N.Y. 1971. 77 pp. \$2.95.

Reports on and compares family and child functioning in two adoption programs (quasi-adoption and traditional adoption) studied by the Children's Aid Society of Pennsylvania and Bryn Mawr College, and evaluates the child's adjustment within each group.

CURRENT RESEARCH IN EARLY CHILDHOOD EDUCATION:

a compilation and analysis for program planners. Annie L. Butler. American Association of Elementary-Kindergarten-Nursery Educators, NEA Center, 1201 16th Street, NW., Washington, D.C. 20036. 1970. 193 pp. \$5.

Summarizes research in early childhood education between 1964 and 1970, including the current scene, intellectual growth, school achievement, and such diverse areas as early stimulation, parent involvement, the importance of learning to learn, and creativity.

CHILDREN WITH HEART DIS-

EASE: a guide for teachers. American Heart Association, 44 East 23d Street, New York, N.Y. 10010. 1971. 15 pp. \$7.40 per 100.

Suggests guidelines for teachers to use in recognizing and managing chil-

dren with signs of illness that may lead to heart disease and children who already have heart problems.

SEX EDUCATION ON FILM: a guide

to visual aids and programs. Laura Singer and Judith Buskin. Teachers College Press, Teachers College, Columbia University, New York, N.Y. 10027. 1971. 170 pp. \$3.95.

Describes audiovisual materials produced in the past decade related to sex education.

STANDARDS FOR DAY CARE CENTERS FOR INFANTS AND CHILDREN UNDER 3 YEARS OF AGE

American Academy of Pediatrics. P.O. Box 1034, Evanston, Ill. 60201. 1971. 23 pp. \$2.

Contains basic standards developed by the Committee on Infant and Preschool Child of the American Academy of Pediatrics for day care for young children.

TRAINING NONPROFESSIONAL COMMUNITY PROJECT LEADERS

Janice R. Neleigh, Frederick L. Newman, C. Elizabeth Madore, and William F. Sears. Behavioral Publications, 2852 Broadway—Morningside Heights, New York, N.Y. 10025. 1959 pp. \$3.25.

Describes a demonstration study conducted by Dona Ana Mental Health Services in Las Cruces, N. Mex., which nonprofessional mental health workers were trained to develop and lead a community service project under the guidance of a professional consultant.

INDIVIDUAL AND GROUP SUPERVISION IN FIELD INSTRUCTION

a research report. Esther Sales and Elizabeth Navarre. School of Social Work, University of Michigan, 100 Frieze Building, Ann Arbor, Mi 48104. 1970. 83 pp. \$2.25.

Reports on a project to test the benefits of group supervision of social work students in agencies as compared with benefits of individual supervision.

U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

PRELIMINARY REPORT: First National Conference of Foster Parents. HEW, OCD, Publication No. (OCD) 72-5. 1971. 62 pp. Single copies free from OCD.

A preliminary report of the First National Conference of Foster Parents held in Chicago, Ill., May 7-9, 1971.

SAFE TOYS FOR YOUR CHILD. HEW, OCD, Children's Bureau. Children's Bureau Publication 473. 1971. 8 pp. 20 cents.

Offers some tips for parents in the use and selection of safe toys for their children.

ISSUES IN HUMAN DEVELOPMENT: an inventory of problems, unfinished business and directions for research. Victor C. Vaughn, III, M.D., editor. HEW, National Institute of

HEW refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; PHS, to Public Health Service; SRS, to Social and Rehabilitation Service; OE, to Office of Education.

Child Health and Human Development. 1971. 217 pp. \$1.75.

Presents 18 papers and extracts of discussions held at a symposium covering such subjects as early influences on children's development, physical and chemical aspects of growth, socialization in early childhood, cognition and learning, adolescence, and the impact of urban environment and institutions on human development.

RESEARCH RELATING TO CHILDREN: bulletin No. 27 (June 1970-February 1971). ERIC Clearinghouse on Early Childhood Education, OE. 1971. 138 pp. \$1.50.

Contains brief descriptions of current or recently completed research studies dealing with child growth and development, special groups of children, the child in the family, socioeconomic and cultural factors, educational factors and services, social services, and health services.

SICKLE CELL ANEMIA. HEW, PHS, National Institute of Arthritis and Metabolic Diseases. 1971. 8 pp. 10 cents.

Describes briefly the cause, symptoms, and treatment of sickle cell anemia and gives current information about the disease.

FOUR-C: COMMUNITY COORDINATED CHILD CARE. HEW, OCD, 1971. 8 pp. Single copies available from OCD.

Describes the concept, goals, and operation of the 4-C program.

VISION SCREENING OF CHILDREN. HEW, PHS, Health Services and Mental Health Administration, Maternal and Child Health Service. PHS publication No. 2042. 1971. 24 pp. 25 cents.

Summarizes the main principles, problems, and methods in vision screening and briefly reviews the estimated prevalence of eye problems among children.

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